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of succession planning and the midwifery leadership role in England**

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**AN EXPLORATORY STUDY INTO THE PERCEPTIONS OF
MATERNITY SERVICE MANAGERS AND MIDWIVES
OF SUCCESSION PLANNING AND THE MIDWIFERY
LEADERSHIP ROLE IN ENGLAND**

by Christina Tucker

**A dissertation submitted to the University of Bristol in accordance with the
requirements of the degree of Doctor of Education in the Faculty of Education**

April 2004

ABSTRACT

The purpose of the study was to investigate the perceptions of Heads of Midwifery (HoM's) and core grades of midwives in relation to succession planning and the midwifery leadership role in England. Recent government initiatives have expedited the development of leaders through a range of educational and policy initiatives, which have placed increasing pressure on midwives and the profession, not only to identify potential leaders, but also to support the growth and development of leadership competencies at all levels within the maternity services.

A qualitative study was employed. This included a three-phase exploration: in-depth interviews with three HoM's, two senior midwives with a national profile and seven core grade midwives. The research confirmed that succession planning and midwifery leadership was indeed in crisis.

The main findings:-

- Effective planning for the future is currently haphazard, uncoordinated and no one person has overall responsibility, a gap particularly noticeable at Trust level.
- Insufficient attention has been paid to developing existing midwifery staff through career pathways. The use of Personal Development Plans and career mapping is not common practice.
- There is an association between continuing the learning process, either informally or formally and developing effective leadership skills
- Informants reported that being able to identify strong, professional and visionary leaders and role models working in a context where there was a supportive framework for CPD, helped to promote the development of leadership.
- Leadership exerts considerable pressure on individuals at whatever level that leadership takes place. Wellness and the ability to enjoy the work environment featured strongly in the results. Leaders, who coped well, had balanced lifestyles, discouraged 'long hours' working and failure to take annual leave entitlements.

Recommendations:-

- Clearly identified staff at Trust level to recognise and encourage potential leaders.
- Open and transparent mechanisms for undertaking Continuing Professional Development.
- Effective use of Personal Development Plans and career mapping.
- Supportive frameworks within Trusts to develop and nurture leaders and provide strategies to achieve a balanced lifestyle.

DEDICATION AND ACKNOWLEDGEMENTS

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Finally, to Bernadette Cox and Sue Levick, whose attention to word processing detail and ability to keep me motivated to finish, my grateful and sincere thanks.

AUTHOR'S DECLARATION

I declare that the work in this dissertation was carried out in accordance with the regulations of the University of Bristol. The work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree.

Any views expressed in the dissertation are those of the author and in no way represent those of the University of Bristol.

The dissertation has not been presented to any other university for examination either in the United Kingdom or overseas.

Signed:

Christina Tucker

Date:

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Abbreviations

| | |
|---------|---|
| ARM | Association of Radical Midwives |
| CEO's | Chief Executive Officers |
| CPD | Continuing Professional Development |
| DoH | Department of Health |
| ENB | English National Board |
| FE | Further Education |
| FIGO | International Federation of Gynaecologists and Obstetricians |
| HEI's | Higher Education Institutes |
| HoM's | Heads of Midwifery |
| HoM, ed | Head of Midwifery Education |
| HRM | Human Resource Management |
| LEO | Leading an Empowerment Organisation |
| NHS | National Health Service |
| NHSU | National Health Service University |
| NICE | National Institute for Clinical Excellence |
| NMC | Nursing and Midwifery Council |
| NICU | Neonatal Intensive Care Unit |
| PCG's | Primary Care Groups |
| PCT's | Primary Care Trusts |
| PDP'S | Personal Development Plans |
| PMR | Perinatal Mortality Rate |
| RCM | Royal College of Midwives |
| RCOG | Royal College of Obstetricians and Gynaecologists |
| UKCC | United Kingdom Central Council for Nursing, Midwifery and Health Visiting |
| WDC | Workforce Development Confederation |

CHAPTER 1

The Background and Context for the Study

1.1 Introduction to the Study

For many years, as a principal lecturer in midwifery education, I have been asked by midwives to give them career advice, particularly for promotional interviews. Many of the midwives aspiring to new senior roles who sought my advice had little or no idea about the demands of the role they were applying for. Even when newly appointed to the role, they were often unaware of the dimensions of the job they had undertaken. For whatever reason, they had felt able to apply for the job and were hopeful that they would grow into it. This indicated to me that the applicants did not appear to have had much/any preliminary support or training, or even mentoring or encouragement about career opportunities or possible career paths. This led me to question the role of succession planning in the maternity services and indeed the larger issue of how to identify and ensure that there is a pool of adequately prepared midwives to take up leadership roles within the service.

In turn, this has led me to ask some questions about midwives' individual motivation to apply for promotional posts, even when they were perhaps not fully cognisant with the job specification and responsibilities they were applying for, why did some put themselves forward and other not? Is the motivating factor a fundamental need for the individual midwife to attain status and increase their earning capacity? The study will also explore a number of questions surrounding the selection and appointment procedures for these more senior posts, particularly the salary grading bands and the scope of the Head of Midwifery Services role (HoM's). The focus of the study is encompassed within the title 'An exploratory study into the perceptions of Maternity Services Managers and Midwives of succession planning and the midwifery leadership role in England'.

1.2 Background to the Study

This study was designed to explore the issue of succession planning in the maternity services for England. Interest in the study developed because of the researcher's

experience in finding very little evidence of formal systems of identifying leadership potential, coaching or enabling midwives to acquire the knowledge and skills which would enable them to be promoted into more senior positions in the health service. Heads of Midwifery (HoM's) seem to be perceived and labelled by the NHS as the same as Nurses and therefore they are managed by Nurse or Human Resource Managers in NHS Trusts, rather than leading or managing the professional service of Midwifery themselves. Evidence of this perception is obvious in recent press releases and Department of Health circulars and reports (DoH, 1999). One consequence of this can be that midwives become a minority profession within the wider body of nursing professionals and, as the dominant group, nurses can drive the agenda for discussion and policy making.

1.3 Context for the Study

The midwife is the essential staffing resource to the maternity services in England. In 1999 there were approximately 33,165 practising midwives in the UK (RCM, 2002), with over 20,000 of these practicing (working) in England.

The maternity services are situated within the acute services framework of the National Health Service (NHS), this means that the main funding for the maternity services is in competition for the same funding and resources as Intensive Care Units, Cardiac Units and Acute and Crisis Care Units. The reasons for this situation are historical however, this being the position, the maternity service and its staffing position is managed within this larger arena of care provision. The maternity services have experienced similar structural changes, with flatter structures and few promotional posts.

At the time of this study England had 214 maternity units, varying in size and complexity of provision, ranging from units with less than 1,000 deliveries up to 8,000 deliveries per annum (Tucker, 1999). Midwives were managed locally by Maternity Services Managers or Heads of Midwifery (HoM's) who were predominantly from the same profession of midwifery. There are exceptions but generally midwives were managed by midwives albeit within the encompassing framework of Nursing.

1.4 The Research Questions

- a What are the perceptions of Maternity Service Managers, HoM's and Midwives of succession planning within the Maternity Services of the NHS in England?
- b What are the tasks/challenges of the leadership role within the Maternity Services?
- c How well do E F and G grade midwives feel prepared for the role of leadership?
- d What are the implications for future leaders of midwifery?

1.5 Research Method

The study is qualitative in nature, informed by elements of grounded theory. The main data collection method used in the study was the semi-structured interviews. There were three phases of data collection. The researcher conducted interviews with midwives at different levels of seniority within the service, so as to get a range of perceptions on the research questions.

Phase 1

Semi-structured interviews were conducted with three heads of midwifery, two from maternity units in the South West and one from the Midlands. The main purpose of the interviews was to explore their career path trajectories and the stages that they had gone through before gaining their post as Head of Midwifery. These interviews highlighted a number of issues and themes which were explored further in the second round of interviews.

Phase 2

Interviews were conducted with two very senior midwives who each had a national role, to gain their perspective on the state of leadership within the midwifery profession.

Phase 3

Interviews with the core grades of midwives at E F and G grades, seven interviews in total.

1.6 The Significance of the Study

This study is significant because it touches upon issues about the continuing professional development of staff which has clear implications for policy makers. With considerable changes occurring in the NHS, particularly the shortages of trained staff, the recruitment and retention of staff is a very high profile problem both for the Department of Health (DoH) and the current government. Recent press releases suggest that over 2,000 midwives left the profession in the year 2000-2001 (RCM, 2001).

It is interesting to note that even the DOH cannot give exact figures of those midwives leaving or indeed returning to the service. Once again, midwives are indistinguishable from nurses. Exact, accurate data is not available therefore this study may shed some light on a professional minority group's perceptions of shortage of applicants for senior leadership positions in today's health service.

Finding out how midwives move from one position/job to another for promotion may help the wider community to understand an individual's motivational goals. To explore how the existing managers were appointed into their posts and how they prepare for their new post and if there was additional training involved may help managers to identify any human resource management (HRM) issues.

The study included those aspiring to leadership roles within the organisation. Insights into how they perceive the organisation, its promotional chances/opportunities may well help HRM managers understand why midwives either choose to stay or leave the Profession.

Of course, it is not just midwifery that is experiencing crises in recruitment and retention, there are similar, if not far worse problems in nursing. This study however, will focus on midwifery and midwives. The final section of this work will suggest implications for development for the Health Service, Department of Health, Royal College of Midwives and Regional Health Authority Leads in Leadership. More locally the results of this study will be disseminated to local NHS Trusts in written and verbal format.

1.7 Structure of the Dissertation

The study will investigate the key issues of succession planning and the leadership role in England, for the Maternity Services.

Chapter 1

Has given the background and context for the study. The research questions are introduced and information is given for the research method chosen and finally a short section on the significance of the study.

Chapter 2

Gives a background context literature review of the NHS context, midwifery leadership, midwifery history, 'medicalisation', resurgence of the midwife, women centred care, leadership and succession planning including concepts of leadership, leadership theories and finally Continuing Professional Development.

Chapter 3

Focuses on the research methodology for the study.

Chapter 4

Concentrates on the findings from the analysis of phase one, two and three of the study and the emerging themes.

Chapter 5

Is the discussion chapter which attempts to extrapolate from the findings of the research to explain and reset in the context of the profession what this method is saying in relationship to the questions asked.

Chapter 6

Takes the main conclusions and explores the implications for the practice of midwifery and recommends for the NHS key areas to be addressed arising from the study.

Chapter 7

Suggestions for future research.

CHAPTER 2

Background Literature Review

2.1 Introduction

Literature which has informed the research study is reviewed and discussed in this chapter.

The main sections are:-

- 2.1 Introduction
- 2.2 The Meaning of Culture
 - 2.2.1 The NHS context
- 2.3 Development of the Midwifery Profession
 - 2.3.1 Midwifery History
 - 2.3.2 Medicalisation of Midwifery
 - 2.3.3 Midwifery Leadership
 - 2.3.4 The Resurgence of the Midwife
 - 2.3.5 Women Centred Care
- 2.4 NHS Initiatives on Leadership Development
 - 2.4.1 Concepts of Leadership
 - 2.4.2 Difficulties of Terminology
 - 2.4.3 Leadership Theories
- 2.5 Continuing Professional Development
 - 2.5.1 Succession Planning
- 2.6 Summary

The chapter will provide a background framework for the whole study and will provide further information about some key issues and generate some further questions to explore in the study. In a qualitative study with elements of grounded theory, the initial literature review and provisional exploration of relevant concepts provides the skeleton framework and background for the focus of the research (Strauss and Corbin, 1990). The contribution midwives make to the lives of mothers and babies has long been recognised by the population (Davis, 2001). Unfortunately that contribution was for many years neither recognised by the NHS pay system or by the management structures within NHS organisation. In 2001, probably for the first time, the NHS and Royal College of

Midwives (RCM) collaborated together on the serious issues of midwifery workforce planning; recruitment and strategies for retention and re-entry against a backdrop of pay modernising negotiations over a number of years. The RCM reached agreement with the NHS on the crucial point of the entry point scale for newly qualified midwives and has put in place a process that will reward the careers of experienced midwives. Something, previous administrations had repeatedly failed to do.

Pay modernisation should undoubtedly help improve recruitment and retention rates in midwifery. Equally important however, will be the impact of the NHS Plan for the future development of the NHS, (1998) on the maternity services. Strategies outlined in the plan include an injection of significant extra funds, the emphasis on public health and the reduction of health inequalities, the call for greater user involvement, the need for clinical excellence and lastly a commitment to developing leadership for the professions.

In this study it is important to consider further the environment in which midwives practice. This involves an explanation of the culture of the NHS and the sub-culture of midwifery itself.

2.2 The Meaning of Culture

In response to a question about their understanding of culture and what they think culture is the generic response from employees within organisations will be “the way we do things around here?” With that in mind it is useful to reflect about what is said about the NHS and its culture. Hutton (2000 p1) refers to ‘big cultural changes right across the health and social care systems’, but as he does not elaborate further it is not clear if there is any substance behind the rhetoric. A more useful way to examine culture is to review how others from other organisations understand organisational behaviour or culture.

Morgan (1986) uses eight metaphors to help our understanding of organisational behaviour. Summarised and refined Morgan suggests the following are components of culture.

- The pattern of interaction

- The language used

- The images and themes explored in conversations

Various rituals of daily routine

The metaphorical approach has become influential in the writing on organisations (Meyerson and Martin 1987). This taxonomy approach to examining culture (see appendix 4) appears to help in understanding the meaning and effect of change on organisations.

Morgan (1986) presents culture as an enactment:

The enactment view of culture leads us to see that organisations are in essence socially constructed realities, that rest as much in the heads and minds of their members as they do in concrete sets of rules and relations (p131).

Others believing the same concept have described culture as:

‘the languages and symbolic media we employ to describe, represent, interpret and theorise what we take to be the facticity of organisational life’ (Grant et al, 1998 p1).

Organisational life is therefore the product of the way it is discussed but in that discussion the organisation shapes those discussions by having rules and policies that effect the relationships within the organisation. According to Mumby and Clair (1997) ‘organisation members create a coherent social reality that frames their sense of who they are’ (p181).

Morgan sees culture as a tool for organisational analysis, many others conclude that Morgan is ignoring the patterns of power and control that may underpin the way in which organisations are enacted (Alvesson, 1993; Holland, 1999). In contrast to Morgan, other discourse theorists view organisations ‘not simply as social collectives where shared meaning is produced but rather as sites of struggle where different groups compete to shape the social reality of organisations in ways that serve their own interests’ (Mumby & Clair, 1996 p182). Meyerson & Martin (1987) accept the premise that cultures are socially constructed realities and that how culture changes depend on how one perceives and enacts culture, even so, they present a scheme of three views of culture and cultural change in the literature which they term ‘integration’, ‘differentiation’ and ‘ambiguity’. This tool has been adopted by others to examine culture (Golden, 1992; Peck et al, 2001) (See appendix 4).

2.2.1 The NHS Context

The NHS has like so many organisations its very own culture or traditions, a way of life characterised by special customs and defined territories. An example of this NHS culture was ‘to do as you’re told’, follow instructions, particularly if the person issuing them was senior to yourself. Consensus management was the order of the day prior to the 1983 re-organisation. The specific concerns of escalating costs to provide the service and the apparent lack of management accountability that came under critical scrutiny in more recent years were in part, because of increasing expenditure from public sources and the pressure this had put on successive governments seeking ways of controlling public spending. Also important has been the perception that those resources allocated to the health services were not managed to obtain optimum efficiency and equity. The introduction of competition into the NHS from 1983 provoked a severe reaction against planning. The current government’s decision to abolish the internal market and encourage co-operation thus heralded a movement away from the extremes of the 1980s and 90s (Ham, 2001).

The 1997 plan for the NHS introduced by 1999, had identified targets such as:

- planning for investment with sustained increases in funding
- reform of the services provided designed around the patient
- providing 199 new hospitals by 2010 and 500 new one-stop primary care units

which presented a formidable challenge that will only be met with the support and commitment of managers at all levels in the NHS organisation.

More fundamentally, emphasis was placed on the development of NHS staff in the Human Resources Framework (NHS, 2000). This report indicates a welcome recognition of the need to invest in people to deliver continuous improvements in performance. The report framework had clear implications for the managers of the service as well as all NHS staff.

The NHS requires its managers and leaders to be knowledgeable and competent at all levels and structures of the organisation in order to take forward its modernisation plans (NHS, 2000).

NHS management development programmes already exist in the form of management training schemes, Opportunity 2000 and chief executive development programmes. There are also examples of individual NHS organisations and university-based management centres providing programmes for practitioner's personal development. Opportunities are available but it is left to the individual managers to organise continuous practice development (CPD) for themselves and the staff in their team. There is however, no coherent approach to management and organisation development across the NHS as a whole, it is fragmented and that which is available is not open to all NHS managers at every level.

One approach suggested by policy makers was to create a national staff college. Advocates of a staff college argue that the NHS needs a dedicated facility to overcome the fragmentation already existing in the current arrangements and to provide a focus for future development of programmes. Opponents of the scheme argue that the NHS is too large for any one single organisation to meet the needs of the whole service. The suggestion that is popular at the moment is to agree a national curriculum to be delivered through a number of management centres linked to universities which would offer programmes for staff management roles irrespective of their training or background. These centres should also be involved in research into management, thus providing an evidence-base for the NHS (Ham, 2001).

2.3 Development of the Midwifery Profession

The many major changes over the past twenty years in the NHS organisation has had to some extent, a negative impact on the nursing and midwifery services. Many of the senior posts have been lost or in some cases, the level of authority and responsibility eroded (Girvin, 1996; Steele, 1997). Leadership opportunities have reduced and the employment of non-clinical managers has further eroded the senior roles that could provide promotional opportunities. However, it is now fair to say there has been a shift in opinion and change in policy since the current government's White Paper DoH, (1997), and the NHS Plan, (2000), have both identified that effective leadership was necessary to ensure quality (DOH,1997; NHS, 2000). Furthermore, in both reports, the emphasis was on leadership at all levels within the service. Subsequent reports from the DOH, (1998) (1999) and the RCM, (2000), have advocated strengthening nursing and midwifery

leadership as one of the pivotal drivers in modernising the NHS, including the maternity services. In order to understand the midwifery culture it is necessary to appraise the reader of midwifery's rich and unique history and salient landmarks. Due to word limitation it is impossible to start before the nineteenth century in any detail, but suffice to say, midwifery has a huge and impressive history before that time, mentioned in the Bible and other historical works, a truly honourable and venerable profession which instils in its practitioners the core disciplines and values of service, self sacrifice, courage, caring and compassion.

2.3.1 Midwifery History

The majority of the workforce within the maternity service are women, with male midwives making up less than 5% of the total. Midwifery historians report that midwives have always operated as autonomous practitioners, self employed and prior to the implementation of the 1946 NHS Act, were outside of the hospital services and truly independent (Towler and Bramall, 1986). The purpose of the English Midwives Act of 1902 was to secure better education for midwives, to regulate their practice under the auspices of statutory supervision and gain a certificate to practise. Domiciliary delivery was the dominant model and doctors and their representative bodies had strongly opposed the training and registration of midwives, wishing to preserve the market for themselves. Safety of childbirth became the overriding issue in both America and the UK in the early part of the twentieth century. Training of medical students and postgraduate medical practitioners in childbirth skills became paramount due to the high maternal death statistics. Two-thirds of the deaths were considered to have been avoidable, due to the incompetence or carelessness of the attendant, whether obstetrician, midwife, general practitioner or surgeon (Stewart, 1981). Regulations were introduced to remedy and particularly, to promote an aseptic environment and to prevent operations by unskilled doctors or midwives, the assumption being that hospitals were the best place for birth and that interventions correctly performed by qualified obstetricians were beneficial. Thus the medicalisation of birth began in earnest on both continents. By 1946, 54% of births in England and Wales were in hospitals of some kind, whereas the percentage in America was 80%. A tempting example for British Obstetricians who saw no reason to resist the temptation, they thought they had the mandate from families and society that doctors knew what was best for birth (Wertz and Wertz, 1997). They had become through a rigorous

programme of postgraduate education, masters of the maternity service. Obstetrician's power and influence was consolidated in 1954 with the formation of the International Federation of Gynaecologists and Obstetricians, FIGO, to promote co-operation and scientific research. FIGO encouraged obstetricians to develop research initiatives which they carried out with enthusiasm and great productivity. Their omission was to ignore the parallel function of evaluating or researching some of the obstetric techniques and interventions and this has had a negative effect on the popularity of the specialism and more latterly may have contributed to the increase in litigation.

2.3.2 Medicalisation of Midwifery

Once domiciliary delivery was virtually eradicated, attention was focused on eliminating the non-specialist hospital, which was deemed unsafe and uneconomic. Obstetricians took over more and more care of women in pregnancy, labour and the postnatal period. Obviously they needed other attendants, but not from a rival profession who subscribed to a conflicting philosophy and claimed independent status. So a different role for midwives had to be designed (Towler and Bramall, 1986: 278). Restrictions in the midwives role to provide holistic care were to some extent mediated by allowing them to develop in a different direction eg. parentcraft, nutrition, family planning, breast feeding and maternal infant bonding or attachment skills. The maternity services were broken up into separate disciplines, antenatal care, labour ward care and postnatal care, obstetricians dictated how wards and departments were structured, managed and staffed. So midwives found themselves employed either in the community or hospitals with a very fragmented role, many lost some of their skills, particularly delivery skills and the ability to follow a pregnancy right through to the postnatal period (Towler and Bramall, 1986: 280). Community midwives working with general practitioners (GP's) were likewise restricted, their function became the postnatal care of mothers and chaperone duties for the GP in providing antenatal care. Conflicts of professional specialisation in the hospital or community setting were supposed to be overcome by working as a multiprofessional team, the team leader being the GP, never the midwife. For midwives had ceased to be independent or autonomous or indeed leaders of their profession but experienced loss of status and became handmaidens to obstetricians with less job satisfaction (Towler and Bramall, 1986: 283). By the 1980s domiciliary midwifery had been all but stamped out, women had great difficulty finding a midwife for a home confinement (Tew, 1997).

2.3.3 Midwifery Leadership

Donnison (1988) has argued that midwifery leaders in the 1970s were weak and ineffectual, so too was the Royal College of Midwives (RCM.). Even in the face of emerging evidence contradicting the accepted obstetric view, they continued to support the premise that childbirth in a domiciliary setting was dangerous (Tew, 1997; Campbell and Macfarlane, 1987).

Midwives and midwife teachers at that time seemed to be subsumed into a hospital and highly technical environment. Midwife managers acquiescing to fragmented care patterns and midwife teachers expanding midwifery curriculum to include extensive technical content (Towler and Bramall, 1986: 260).

The second change began with a small group of midwives in 1976, who believed in the rightness of physiological birth and holistic approaches to women-centred care. This group was latterly called the Association of Radical Midwives (ARM.), ‘radical’ signifying the need to return to the original philosophy and fundamental art and science of midwifery. Over the next fifteen years the ARM and the formal RCM organisations came closer together, particularly when the RCM realised that the future of the profession was at stake.

2.3.4 The Resurgence of the Midwife

Successive government reports have queried the organisation of the maternity services and the domination of the obstetricians. The Guillebrand Committee (1956); and Cranbrook Report (1959); stated ‘the advantages of home confinement for the apparently normal case probably outweighs the very slight risk of unforeseen complications’ (22 para 57) and further stated ‘nothing should be done to lessen the importance of the midwife’ (22 para 107). However, they also recommended a contraction of the domiciliary midwifery service and the midwife’s authority was further diminished when the report recommended that a ‘general practitioner obstetrician should, whenever possible, attend all domiciliary confinements, to safeguard the mother and baby against unforeseen emergencies’ (22 para 212). Hospitalisation for confinement was advanced by the powerful obstetricians and the

Regional Hospital Boards, whilst the midwives continued to oppose all such claims. Consumers were generally swayed by the claims for increased safety although there was no evaluation of such claims. Thus by the late 1960s everyone was now indoctrinated to accept the medical view that childbearing was an illness and as such should be treated like other illnesses, in hospital. This was further compounded by the Peel Report (1970) which advocated 100% hospital confinement and suggested that midwives should assist obstetricians in their scientific management of labour. Meanwhile, midwives working in the community were allowed to undertake those tasks which were on the periphery of childbearing (eg. mothercraft, breastfeeding etc), those tasks which obstetricians were not interested in developing. The result for the women was less choice and less control of the process.

Concern for perinatal mortality rates, promoted another report, the Short Report (1980). The committee was concerned that the perinatal mortality rate (PMR), was much higher in the lower social classes than the higher. Despite the great increase in births in hospital and in the use of advanced equipment since the 1960s, the gap had widened. Likewise, preferential allocation of medical resources to the less wealthy regions had failed to reduce the relative excess PMR and like the Cranbrook and Peel Committees, the Short Report recommended that midwives should regain their former status (31 para 249). The Short Report however, still advocated that hospital was the safest place for confinement. Midwives were still expected to persuade women that hospital was the safest place, also emphasising the potential dangers of birth. The medical advisors ensured that this committee conformed with the interests of the dominant profession, even when the follow-up report was published in 1984 finding that there was still room for the more carefully defined and better used skills of both midwives and GP's in maternity care. Opportunities for midwives had been slightly increased through the few low-risk birth rooms which had been set up in consultant units. Reforms which the committee had recommended included 'humanising obstetric care' (36 para 40) thereby providing a more comfortable and homely environment in antenatal clinics, labour suites, with flexible visiting, adopting different birthing positions and keeping the baby with the mother throughout the postnatal period. Consumer interest and pressure were responsible for this change.

2.3.5 Women Centred Care

In 1991 a comprehensive inquiry, the Winterton report, into the maternity services was set up and began reporting in 1992. The report sought to reconcile the conflicting evidence and opinions submitted by the users of the maternity services and its providers. The committee was convinced that maternal satisfaction was not a trivial consideration, distinct from and much subordinated to safety, but indeed had lasting implications for physical, psychological and social care. Most women wanted a wider choice of place of delivery and the committee was convinced that the constantly repeated unsubstantiated assertions of obstetricians that hospital was the safest place could not be justified any longer on the grounds of safety (44 para 33). They concluded that the medical model of maternity care provision was based on unproven statistics. Weighing up the evidence it had received, the committee found that service providers including midwives were insufficiently informed and perhaps ignorant of the women's own criteria for successful care and that compliance with their criteria was hindered by territorial disputes and professional rivalry (44 para 191). The committee further recommended that for the majority of women, whose pregnancies were normal, their care should be community/domiciliary based, under the direct control of midwives who are the specialists in normal childbirth. Naturally GP's and consultant obstetricians would not agree to these recommendations being adopted, even though the shortages in medical personnel would be relieved somewhat and the committee recommended that an investigation into the working practices of obstetricians be undertaken. Finally, the report recommended radical restructuring of the maternity services and the Department of Health set up an Expert Maternity Group to consider the practical implication of the changes, and to determine future policy.

Nine months later, the new Expert Maternity Group (1993) proposed:-

‘The woman must be the focus of maternity care. She should be able to feel she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved’ (52, p 8).

Safety remains at the heart of midwifery care, no one feels more strongly about safety than the baby's mother. She should choose the professional who would be responsible for leading and providing continuity of care and carer throughout. Most women choose the midwife, the Expert Group recommended that:

‘Within 5 years, 75% of women should be cared for in labour by a midwife they have come to know in pregnancy’ (52, 2.3, 2.4).

The expert group deplored duplication and obstetricians faced the prospect of losing most or all of their domain to midwives and GP's. Only those women deemed 'high risk' or those who expressed a preference for their care would be seen by the obstetrician. Education and training for midwives, GP's and obstetricians was updated to emphasise a balance of clinical skills and knowledge and interpersonal and communication skills, as well as for midwives, community/domiciliary working. The profession gave an assurance that midwives were legally responsible and accountable for the care they gave (UKCC 1998) however, the safety issue remains a contradiction even today. Centuries of what promotes safety in childbirth, different philosophies and now an emerging body of literature that supports the argument that in most cases, childbirth is safest with the least interference, is still contested by members of the different professions. The Royal College of Obstetricians and Gynaecologists (RCOG) did not wholly concord with the expert group's recommendations declaring:

‘That so much trust should be placed in midwives who are not trained to diagnose general morbidity in mothers is deplorable’ (Simmons, 1993).

To some extent the RCOG continues to undermine the (1993) report and they can still exert considerable political power to foil, delay and frustrate the intentions of policy makers and prevent the general implementation of the report (Tew, 1998: 382).

In summary, the midwifery profession has over a number of years established itself as a separate and 'distinct profession' but finds itself within the larger structures of the NHS as having lost some positional power and the ability to self manage.

Having examined the salient issues for the Midwifery profession and the culture of the NHS, the next section will focus on the literature around leadership theories, concepts, terminology, leadership in the NHS and succession planning.

2.4 NHS Initiatives on Leadership Development

With the many changes in the NHS over the last 20 years, including the erosion of many senior posts, leadership opportunities for nurses and midwives have diminished (Girvin, 1996; Steele, 1997), many of the managerial decisions are now undertaken by non-clinical managerial staff.

The (1997) Government White Paper identified that effective leadership was necessary to ensure quality with the NHS, (DOH, 1997) at all levels. Further government reports DOH, (1999); DOH, (2000); and DOH, (1998) explicitly made reference to improving leadership within nursing and midwifery. Part of the government's agenda involves identification, support and development of future leaders DOH, (1998); DOH, (1999); DOH, (2000). By actively nurturing potential leaders to stand up and undertake risks and challenge convention and cultures found in the NHS organisation, we should ensure succession planning. Steele (1997), states that this type of succession planning should ensure a 'continuous flow of effective leaders' 214. Going on to further elaborate, Hillan (2000) states that it is essential for midwifery leaders to be 'exposed to the right kind of intellectual challenge' 114.

The issue of developing strong effective leadership becomes paramount in the practice settings, ie. clinical leadership and how leadership is defined and how theories emerge and impact on the organisational culture of the NHS and more particularly on the Maternity Services.

2.4 1 Concepts of Leadership

It is evident that there are numerous definitions of the concept of leadership 'often ambiguous and even contradictory' (Klenke, 1999:9). Stewart (1996) notes that individuals are able to recognise leadership be it good or bad, however, when asked to define it difficulties occur. Factors such as the organisational settings and the environment

will impact on its sense. The most commonly used word in formal definitions is 'influence'. How one individual is able to influence another individual or group towards achieving a particular goal. Cross (1996) suggests that to influence is only one part of the leadership process and that communication plays an equally important role if leadership is to be effective. Leadership is much more than achieving results, it is about sharing a vision and developing a cohesive team.

Klenke (1996) argues that by formally defining leadership, it limits a person's ability to form opinions and to critically analyse in different situations. Klenke goes on to suggest that the values of teamwork and collaboration between the leader and followers are essential to a dynamic, thriving organisation. Much literature is devoted to exploring the qualities of effective leaders. These skills can be divided into firstly, basic qualities, such as communication skills, personality, basic understanding and sensitivity and secondly, personal qualities, of self awareness, the ability to be objective, rational and inspiring but yet a person, who appreciates the followers and their abilities and indeed encourages their development. Other writers use terms such as dependability, integrity, drive, confidence and fairness (Cross, 1996; Huczynski and Buchanan, 1991; Palmer, 1998; Girvin, 1996).

2.4.2 Difficulties of Terminology

Leadership is a curious quality, often asked for on job applications, so therefore it must be presumed it can be learned. Management is often defined as achieving objectives through the work of others. So a good manager is perhaps also a good leader - although it is not clear whether leadership is a component of good management or whether good management is a facet of good leadership (Ainsworth, 2001). The quality of being a leader is certainly not something which is simply acquired with a managerial appointment. Being a leader is primarily a personal characteristic. Critics of leadership argue that leadership is in fact little more than the ability to dominate others. What turns a potential leader into an active leader is, when that potential coincides with the desire and chance to dominate: the means, the motive and the opportunity. The NHS like all organisations needs people to lead the way and managers to ensure the objectives are met.

Recent research by Alimo-Metcalfe, (2001) involving some 2,000 NHS managers, has revealed a clear profile of the leadership qualities seen as important, at the very top of the

list was genuine concern for others. This includes showing a genuine interest in staff as individuals, seeing the world through their eyes, valuing their contributions, developing their strengths, coaching, mentoring and having positive expectations of what staff can achieve. Professor David Hunter (1999) suggests that an essential function of the manager in the public service sector is to guide and support the work of others rather than to seek status and power over them. This, Hunter refers to as a 'servant leader' someone who puts his/her followers needs and expectations first.

Alimo-Metcalfe and Alban-Metcalfe's, (2000) research findings confirm the staggering complexity of the role of leadership in the NHS and that the traditional transactional competencies of management, while crucial, are simply not sufficient on their own. Clearly the models of leadership previously espoused, that put overwhelming emphasis on charisma and vision and acting as role models for followers, are inappropriate for the NHS.

Alimo-Metcalfe and Alban-Metcalfe found that the most important pre-requisite attribute for the leader is what they can do for their staff, this finding is similar to the model propounded by Hunter, (1999) 'the leader as servant'. The 2,000 staff who participated in this research were also saying that leadership was fundamentally about engaging others as partners in developing and achieving the shared vision and enabling them to lead. It is also about creating a fertile, supportive environment for creative thinking, for challenging assumptions about how health care should be delivered. Another positive feature of the findings is that the model reflects the modernisation agenda, including partnership working, valuing staff, aiming for best practice and a closer sensitivity to the needs of a range of stakeholders.

Developing leaders to be servant leaders will require support from the NHS and DoH Centres. It will involve a culture change for the organisation. It is highly likely that the current top and senior managers were not selected for these posts on the basis of possessing a transformational style of leadership. Clearly, unless these managers support and nurture the change, the change will fail. The NHS Centre if it is to deliver on its modernisation programme will have to tackle the senior managers with appraisal and retraining initiatives.

Table 1

| <u>Qualities of leadership NHS staff want in order of importance:</u> |
|---|
| Inspirational communicator, networker and achiever |
| Empowering others to lead |
| Transparency |
| Accessibility, approachability and flexibility |
| Decisiveness, determination, readiness to take risks |
| Ability to draw people together with a shared vision |
| Charisma |
| Encouraging challenges to the status quo |
| Supporting a development culture |
| Ability to analyse and think creatively |
| Managing change sensitively and skilfully |

Reference: Alimo-Metcalfe, B. Alban-Metcalfe, R. (2000)

Therefore, it is concluded that individuals at whatever level in the organisation should have the potential to be leaders, even if it is not necessarily associated with a management position. Schermerhorn et al (1991) refers to this as the formal and informal leaders. The informal leaders are able to influence others through their individual qualities and characteristics, whereas formal leaders can influence and control through the management of resources and the exertion of position power.

2.4.3 Leadership Theories

Leadership theories styles and traits have been developed by researchers over a number of years.

Galton's (1869) 'great man theory' - Galton suggested that individuals were born to lead. As previously described, a number of the highly desirable qualities fit with the trait theory; physical characteristics; mental dexterity and even personality, the tall, fit, above average intelligence, adaptable person who can exercise self control (Klenke, 1996). Critics of the

trait theory argue that whilst there may be some truth in the trait theory, it does not guarantee an effective leader and that subsequent research has suggested that many successful leaders do not possess the major traits (Handy, 1993; Klenke, 1996). Fleschman in the 1940s proposed the idea of leader-behaviour styles, 'It is not who the leader is that is important, but what the leader does'. This approach to leadership is based on a continuum between an authoritarian or autocratic style and at the other end of the continuum, democratic style of leadership. A third approach more latterly introduced is the 'laissez-faire' style, this is characterised by a permissive, non-directive style of leading where the emphasis is on the group leading itself.

Most research has found that utilising the democratic approach achieves better results and leads to greater satisfaction of team members (Handy, 1993; Klenke, 1996; Cross, 1996). Situational and contingency leadership theories developed during the 1960s and 1970s Blake and Mouton, (1964); Blanchard, Hersey and Johnson, (1996). The models identified leadership behaviours that support growth and development. In the model the authors suggest that there is:

No one best leadership style, thus suggesting that the earlier theories, which suggested that 'one style fits all' is incorrect.

They argue that leaders need to master at least the four styles of supporting, coaching, directing and delegating and that they should also be able to assess where and what type of style the followers need and that every follower, in each of the quadrants requires specific and individual appropriate directive and supportive behaviour from the leader. Finally, to remember that flexibility is important, because no two followers come to a situation with identical skills, knowledge, motivation or confidence. Ultimately, the leader's style is determined by the follower's needs.

Handy (1993), argues that there are five sources of power; physical; resource or reward; position or legitimate; expert; and personal power. Within the sphere of management power it is used within three domains, power over, where the leader uses position or legitimate power to dominate the followers. Power to; whereby the leader gives power to the followers to make their own decisions, this is also called effective delegation. Lastly, power from; the reverse of delegation, leaders remove or dismiss ideas or decisions of

their subordinates (Rosenbach and Taylor, 1993). Leaders therefore will lead and exert power in many different ways.

During the 1980s transformational (or spiritual) leadership theories emerged Alimo-Metcalfe (1995); Kouzes and Posner (1995). The notion of visionary leadership Allen, (1995) Bowling, (1997) and feminine leadership are closely linked, suggesting that transformational behaviour came more easily to women than men (Rosener, 1990; Alimo-Metcalfe, 1995) and this fact may be highly relevant to the health professions, whose staff are predominantly female. The emphasis of this type of leadership is upon motivating and stimulating the spirit of the group, its sense of vitality, energy, vision and purpose. The transformational leader is a leader who commits people to action, who converts followers to leaders and converts leaders into agents of change. Thus, the workplace is transformed, productive and more responsive than its conventional counterparts (Bass and Avolio, 1994; Porter-O'Grady, 1992; Trofino, 1993). Their leaders are more likely to be viewed as credible (Muller-Smith, 1993) and are likely to make a more significant contribution.

Prior to the 1980s theories around leadership were developed by men about men. The very term leadership has for a long time been almost synonymous with masculinity. All research that was carried out into leadership dealt almost exclusively with male leaders. Women leaders are viewed more negatively than their male counterparts or ignored (Rosener, 1990; Alimo-Metcalfe, 1995). However, when researchers tested for gender differences in leader behaviour, leader-follower relationships and leader success, no significant differences between genders were found (Alimo-Metcalfe, 1995; Malby, 1997; Helgesen, 1990). This problem of lack of women leaders has been highlighted many times in the literature and still today, despite positive initiatives from organisations, and governmental offices, DoH, (1999) Opportunity (2000), the need for strong women leadership has never been greater. The DOH (1999) recommends an investment in continuing professional development to support and develop leaders and this poses fundamental questions for health professionals, particularly nurses and midwives, who are predominantly female, how do you identify, develop and support the right kind of leader and leadership? (Bowles and Bowles, 1999). What is required are good examples or models of female leadership.

Recent health care reforms and modernisation policies, such as the creation of Primary Care Groups and now Trusts (PCG's and PCT's) and the development of frameworks for clinical governance, technological initiatives and new services such as NHS Direct, recognise the value of the health care practitioner being self-determining and finding new ways of working.

Making a Difference (DOH, 1999) challenges nurses and midwives to develop different approaches to care, set the pace for change and confidently respond to those demands. Finding the tools and skills to deliver on this new agenda requires creative innovators and entrepreneurs and some financial investment, together with the ability to challenge the status quo and become risk takers even in the face of failure. What is needed now is to recognise, develop and nurture talented individuals who can take the organisation forward. Traditionally, the NHS has relied upon an appraisal system to convey to its staff the concept of a regular and systematic self-evaluation of his or her own practice. Appraisal and staff development contributes to the process of reviewing organisational performance, at ward or department and institutional level. Appraisal is conducted by the line manager who has management responsibility for planning and selecting the individual's work programmes, setting priorities and allocating resources for staff development. The managers themselves are also subject to a systematic performance review. How often this process is implemented in the NHS is questionable. At unit management level it is likely to be more formalised or co-ordinated and is totally dependent on clear guidelines from individual NHS Trust personnel departments. The ideal process would include the appraisee's reflecting on their aspirations and developmental needs with questions around their main goals for the coming year and identifying specific training needs as well as how they see their careers developing.

The NHS is concerned about the ageing population of its workforce, with a considerable number of its experienced staff retiring within the next 5-10 years. This has prompted a rush of activity, particularly to recruit more nurses and midwives, even by recruiting from those countries which have a surplus such as Malaysia and the Philippines. This of course will not address the main problems of scarce human resources. The NHS needs to work simultaneously on workforce planning issues, of competence levels of staff and morale issues, which should value staff as assets rather than costs to be reduced, whilst encouraging individuals into the health service by widening participation into Higher

Education and the Health Service (HEFC, 2001). This may include collaboration with Further Education Colleges (FE), targeting schools and other organisations to encourage recruitment into the Health Service, developing a collaborative approach with FE colleges to provide foundational courses, especially in professional discipline areas with extreme shortages of recruits, eg. therapeutic radiography and some of the branches of nursing eg. learning disabilities and mental health nursing.

Concern for the existing staff becomes paramount in retention issues, thus concentrating on those still working in the wards and departments may bring some stability to the workforce, succession planning needs a formal planning strategy. This is new to the NHS. Industrial and business organisations are much further ahead of the public services, identifying, coaching and supporting employees with potential to lead is a recognised strategy in most reputable businesses.

2.5 Continuing Professional Development

Positive career development has to be backed up by appropriate educational development however, many nurses and midwives are unclear as to where to go to find advice on career opportunities and education. Recently, the NHS has invested in a programme developed in Leeds for the UK market, by an American company - Leading an Empowerment Organisation (LEO, 1997). This is not linked to the staff college previously mentioned but it is a UK initiative supported by both the NHS and the Department of Health (DoH). The hope is that all nurses and midwives at 'G' Grade will undertake the 3 day programme, which aims to provide the participants with knowledge of leadership styles, the components of management and leadership roles and the skills to develop and support the growth of followers. Figures show that by May 2002 about 1350 midwives had undertaken this national programme (RCM, 2003). It is designed to look at strategies for solving problems and provides models for moving forward and sustaining change. The core parts of the programme are about working together, dealing with conflict and getting the best out of people (workforce), empowering teams to behave and respond as responsible adults.

Adams (1996) argues that this is a 'sticking plaster' approach because the training programme lasts only two or three days. The course participants hear about leadership

theory, participate in behavioural exercises and leave the course with enthusiasm to try out their new skills. However, respondents report that upon returning to their own jobs, they may have some short-term success, disappointment however, may follow within a few weeks, when they return to old habits.

Trying to reduce a lifetime of work traits, that come from knowing yourself, to short skill development sessions, over simplifies the process, is not time specific, or necessarily tailored to the leaders environment.

Cynics of the LEO programmes, suggest that it is 'a quick fix approach' (Adams 1996) and like a lot of initiatives in the NHS, it has not yet been thoroughly evaluated. Two or three comprehensive studies have been undertaken (Gulland, 1998; Werrett et al, 2002; Cooper, 2003). These studies reported that respondents' rate the three day programmes favourably. The organisation and presentation of the material was well received and the programme in the main was reported to be user friendly, informative and relevant. Some negative aspects were also reported mainly concerned about the language of the materials being jargonistic and 'Americanised'. Generally the feedback from the research generated comments from the respondent's personal perspective on development, ie. they had a better understanding of leadership, they could identify their own strengths and weaknesses. The programme gave them time to reflect and time out of the working environment and it gave their confidence and assertiveness behaviour a boost. Werrett et al (2002) set out to evaluate whether the LEO programme had had an impact on clinical care, this was more difficult for the researchers to prove as the majority of respondents did not give specific examples. However, the respondents did use phrases or single word responses that indicated that some influence or differences had been noted by them, such as 'learning to delegate', 'increase use of assertiveness skills', and commenting on team building and team support as more positive. Being able to articulate their expectations to their team members, some felt empowered to reflect on practice. A few respondents noticed they were more patient focussed. Cooper's (2003) study aimed to evaluate the effectiveness of the LEO training programmes by examining pre-existing leadership skills, based upon self and team member's reports and comparing them with skills on completion of the programme (a pre and post evaluation). The questionnaire tool enabled quantitative and qualitative data analysis of a Leadership Behaviour Description (LBD) questionnaire (form X11) and the Team Excellence version 2 (TEV2) (Kolb, 1995). Several researchers

have previously demonstrated the reliability of these questionnaires (Larson and La Fasto, 1989; Kouzes Posner, 1990). The results from the fifteen respondents demonstrated a statistically significant improvement in the following leadership items, articulating the goal, maintaining organisational objectives, exhibiting trust, presenting challenging opportunities and getting outside support. The results indicate that the respondents believed their leadership performance had improved. From the qualitative data the key themes which emerged illustrated a number of inadequacies which the LEO programme will need to address, namely, conflict between the nursing and management role and the entry level of the Nurse/Midwife and the appropriateness of the programme. Respondents tended to state that the programme would be most appropriate for grades 'E' and 'F' and other junior grades. They also indicated that they were not prepared for the course. Other than receipt of an introductory letter very little information and no preparatory work was supplied. Interestingly, a variety of improvements were suggested such as the inclusion of more activist and reflective tasks into the programme, including role play and course assignments, feedback and mentorship, which are essential components of leadership development and finally that the programmes should be multiprofessional (Mires et al, 1999) and that they wanted more feedback and ongoing mentorship. Currently, there is no structured follow-up mechanism after LEO. Other leadership programmes (eg. the RCN Leadership Development Course) indicate that leadership development is an incremental process requiring a period of mentorship. This could be effectively implemented as a system of peer review, with work-based mentors (Cooper, 2003).

From these findings it is clear there is a positive effect on the majority of the respondents in the studies, however, researchers (NLC, 2000; Goodwin, 2000; Duffin, 2001) report the need for longitudinal reviews to judge whether the programme has a sustainable positive influence on the course members, whether it impacts on clinical care positively over time.

Leadership development for heads of midwifery is also high on this government's agenda. The Midwifery Leadership Development Project, sponsored by the Department of Health National Leadership Centre has identified three main roles for HoM's. These three main roles are;-

- (i) Leader of Midwives
- (ii) Advocate for Women and Children
- (iii) Manager in the NHS

Jenny Leggott, the project leader, believes it is about implementing the NHS plan, valuing staff, leadership capacity building and investing in people.

During the autumn and winter of 2003 HoM's and acting HoM's in England were offered the opportunity to assess themselves against the Midwifery Competency Leadership Model by attending a development centre for two days. Fourteen development centres were involved and 135 HoM's attended. The resulting data from these centres is awaited in the final report (RCM, 2004 Personal Communication). More recently Workforce Development Confederations (WDC) up and down the country are advertising a range of leadership initiatives which they are funding, linked to the NHS Leadership Centre schemes but run locally. These include, Gateway to Leadership based on an 18 month programme and courses run by the NHS Leadership Centre, based on the Leadership Qualities Framework. The WDC believes in the importance of leadership at all levels of the NHS to improve patient-centred services, they will commission, develop and evaluate schemes to ensure they are practice based.

Leadership development is a long-term proposition that requires change in the individual's practice and thinking. Acknowledging this premise should be part of an organisation's strategy for future development of its leaders.

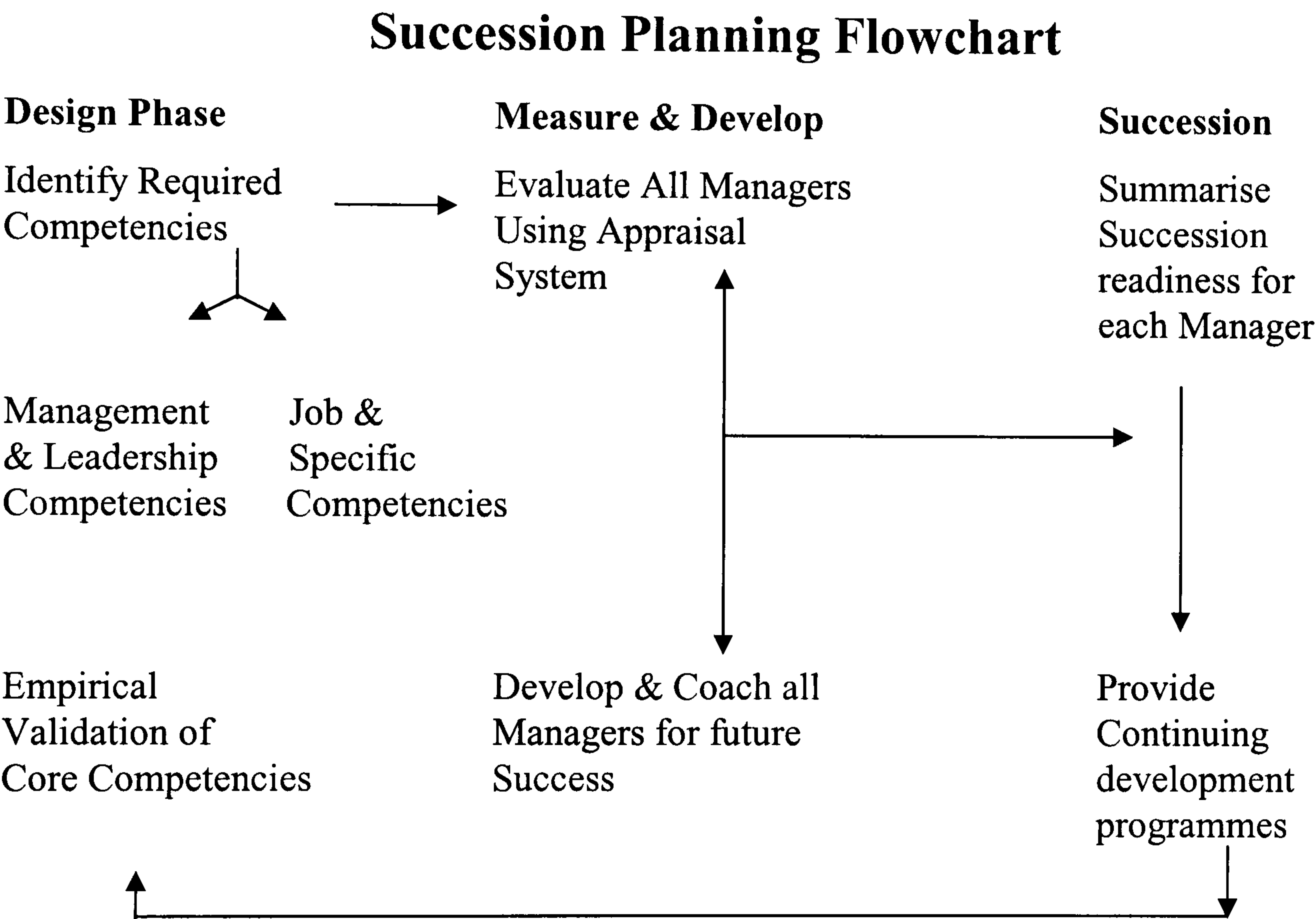
2.5.1 Succession Planning

Succession planning is not just about identifying a cadre of potential leaders. It is about developing those persons so they have the opportunity to develop leadership competencies and have the opportunity to experience the job, either by shadowing the leader or having a secondment opportunity to act into the actual leader role. In the past, succession planning focused on the preparation of talented individuals, today organisations increasingly work in teams, as does the NHS. Therefore, succession management needs to focus on the individual in the context of leadership and how to add value to team performance.

Succession management is new to the NHS. In the past the appointment of senior leaders was shrouded in mystery and reflected a paternalistic closed, top-down process, with little input from the candidate. With a more transparent approach to appointments the responsibility for career progression rests with individuals. However, if individual

midwives are to become aware of the career possibilities/opportunities, many employers need to engage in dialogue with potential candidates. It requires all organisations to engage in this process (see table 2), to develop a strategy for objectively assessing, identifying and developing high potential employees, as well as outside candidates, aligning the organisations strategic goals and competencies for future leadership, thus building pools of potential leaders, not queues (Hagberg, 2000; Fruth 2003).

Table 2



Adapted from Hagberg Consulting Group (1998) Foster City L.A.

Identifying, developing and promoting individuals who show leadership potential and aligning them to the competencies needed in the organisation and providing specific training for leaders is essential if the organisation is to succeed and maximise its human potential assets.

2.6 Summary

This chapter has reviewed the main themes that have emerged from the literature which has formed the background reading and subsequent reading of the researcher whilst

undertaking this study over a number of years. Leadership is a complex concept exercised in many ways at different times during the life of an organisation. The NHS organisation is a vast monolith, difficult to regulate, manage and control, broken down into numerous and various parts, eg. Trusts and Primary Care Groups (PCG's) and since the 1st April 2002, Primary Care Trusts (PCT's). Its workforce is a mixture of professional, administrative and ancillary staff with competing and sometimes conflicting agendas. Each of the professional groups has, to some extent, entrenched views of how the organisation should be run and although all have the client/patient at the centre of their care, bickering, professional rivalries and a lack of clear boundaries between the professional groups often confuses the pathways of care for the recipient of the service.

The NHS regions have varied in their approach to leadership development and succession planning. What is important is that best practice is replicated across the whole health service. The NHS would do well to copy industry and develop systems to ensure senior clinical managers are firstly trained and then act with honesty and probity to ensure management governance in the complex and constantly changing world of the NHS. Identifying leaders and preparing the next generation through succession planning strategies is absolutely essential for the future. The literature review reveals that there appears to be a general lack of identification, nurturing or training of potential candidates for leadership appointments within the NHS and in particular within Midwifery. Little data is available from the Department of Health on midwives as a group as the tendency is to include midwives with nurses.

This chapter has examined the background or context of this study. Literature has been used to describe the NHS context, midwifery profession and history. Key defining concepts of midwifery leadership, midwifery development, the evolving of women centred care and the professionalisation of Midwifery is explored. Concepts, theories and terminology of leadership are addressed including research about leadership in the NHS. Finally, literature about professional development and succession planning has been examined. These issues raised in the literature will be revisited when discussing the findings from the research and the implications of the data.

CHAPTER 3

Research Design

3.1 Introduction

The review of the literature on the NHS culture, midwifery culture and leadership theories and succession planning in the previous chapter identified some key questions for investigation. This chapter discusses the research design and data collection methods adopted for this study. It describes the rationale for the procedures used in data collection.

3.2 Rationale for the Research Design

The focus for the study depended on the research questions:-

- a What are the perceptions of Maternity Service Managers, HoM's and Midwives of succession planning within the Maternity Services of the NHS in England?
- b What are the tasks/challenges of the leadership role within the Maternity Services?
- c How well do E, F, and G grade midwives feel prepared for the role of leadership?
- d What are the implication for future leaders in midwifery?

The researcher decided to follow a qualitative framework utilising elements of grounded theory (Strauss and Glaser, 1967). The reason for this approach was because one of the key features of qualitative research is that it explores the ideas and perceptions of others, giving the informant's point of view (Cluett and Bluff 2000:18). This is based on the concept that the informants are best placed to describe their own thoughts and views.

3.2(i) Data Collection

Phase 1 of data collection: The researcher identified three experienced Maternity Service Managers in 1998, and interviewed them separately about their career stories. These three managers were selected because two were local to the researcher's base and when approached were keen to participate in the study. The third manager was known to the researcher through a senior manager's forum. She expressed interest in being part of the

study because she had similar concerns about the state of leadership in the maternity services. The interviews were tape-recorded. The researcher asked them seven semi-structured questions about their lives and career to date, particularly stressing their career pathway and progression until they reached their current role of HoM.

This background reading and a search of all recent literature about leadership from management and professional Nursing and Midwifery CD-ROM databases, utilising CINAHL (Cumulative Index to Nursing and Allied Health Literature), BNI (British Nursing Index), EMBASE (Excerpta Medica Database), HMIC (Health Management Information Consortium), AMED (Allied and Alternative Medicine), formed the construction of the interview.

The semi-structured interview schedule was based on an analysis of the literature review on leaders, leadership style career pathways of significant leaders and succession planning. A copy of the interview schedule is included in appendix 5.

Each taped interview took approximately 45 minutes to conduct, in their own environments, with a short period of time before and after the interviews to ensure the respondent's were satisfied that they had had sufficient time to engage with the questions. Standard procedures were followed for obtaining informed consent and ensuring anonymity as required by the ethics committee. The researcher made it clear to the informants that she would endeavour to maintain anonymity by removing elements of the data that might identify them. Transcribing the tapes followed as soon as possible after the interviews in order to capture the data and ensure that the researcher had the correct interpretation of the findings.

Phase 2 of Data Collection: During Phase 1 of data collection it became clear that a number of stakeholders, of which DoH and the statutory body (ENB) were the most significant, as they had a vested interest in the future of leadership preparation and succession planning. Arrangements were made in 1998/9 to undertake face to face interviews with a key midwife representative at the Department of Health (England) and a key midwife involved in education and practice at the English National Board (ENB). Both these midwives have a national role in policy making so had considerable influence within the National Health Service (NHS).

The researcher considered expanding the stakeholder process by interviewing the chief executive officers of NHS Trusts, but rejected this finally because of time and because a considerable amount of literature already exists in NHS contemporary databases about the views of CEO's of NHS Trusts on leadership.

The question to be raised with these senior stakeholders was, did these key midwives believe that there would be at some point, a leadership crises due to the failure of the profession to ensure suitable midwives were coming forward to take up the leadership role.

The next step of the research process was to construct a short semi-structured interview schedule, (see appendix 6) for the interviews with these two key stakeholder midwives. These interviews were conducted in their place of work and were not tape recorded. Both key midwives were open and frank in their responses, confirming that the midwifery profession did have a foreshadowed crisis of leadership and succession planning.

Phase 3 of data collection: Interviews were conducted with a number of midwives at E, F and G grades, seven in total. The researcher felt it was important to elicit from those aspiring to leadership positions, how they viewed the process or opportunities available to them. The researcher contacted a number of NHS health care Trusts by letter inviting midwives of all grades to come and meet with her to discuss career pathways. The letter gave a number of dates and times when the researcher would be available. The invitation letter clearly stated why the researcher was interested in interviewing midwives. This then became the third phase of the research process. Over a number of dates and times, two 'E' grade midwives, two 'F' grade midwives and three 'G' grade midwives responded to the invitation and were interviewed. The interview schedule used (see appendix 7) was constructed from the main themes of the preceding interviews. The analysis of the interviews followed the same pattern of coding and progressive thematic focussing as described in this chapter.

Table 3

Phases of the Research

| Phase 1 | Phase 2 | Phase 3 |
|--|--|---|
| 1998 In-depth interviews 3 Heads of Midwifery | 1999 In-depth interviews two high profile national midwives | 2000 In-depth interviews:- 2 'E' grade midwives 2 'F' grade midwives 3 'G' grade midwives |
| 1998 - Literature Review <div>→ 2003</div> | | |
| 2003 Writing-up phase | | |

3.2(ii) Discussion of Data Collection

It is a fact that interviewing in qualitative research is very rarely given much attention in standard textbooks on qualitative research, more specialised texts need to be examined to gain practical advice. However, interviewing and its precise description, interview style, terminology, timing, structure were considered and, similar to many other qualitative studies, a semi-structured interview schedule was utilised with questions organised around key themes but allowing considerable flexibility in scope and depth (Polit and Hungler 1991). These interviews were conducted on a one-time basis and face to face at the informant's place of work or home. When interviewing the 'E' grade midwives who were reticent at first, each interview commenced with an open question, such as, 'tell me about your new role here' to settle and relax them. It was important not to lead the informants in their responses as this would compromise the trustworthiness of the study. However, probes were used such as, 'What do you mean by?' and 'Can you expand on that point ...?' to encourage the informants to talk and for clarification and elaboration. The researcher's skills developed as the interviews were conducted, particularly when the two senior midwives with national profiles did not want their interviews tape recorded. Notes were taken during the interviews and the informants were subsequently asked to check them.

After each interview each informant was given the opportunity to tell the researcher about anything else they felt they wanted to say that may not have been covered. The researcher made provision to contact the informants after the interview and send notes back to interviewees to check for accuracy, should clarification on the points raised in the interview be unclear to them. This process of validation of their responses was not required by the midwives or HoM's, however, the two senior midwives did request a copy of the transcript and notes that had been made which were duly sent. The information from the interviews was audio taped, the researcher having practised this procedure, hopefully minimising some of the problems associated with the technique such as; failure to pick up informant's voice and extraneous noise. This was then followed by the process of collection and recording, capturing important information, making field notes and undertaking the analysis of the tape recordings whilst fresh in the memory. The analysis of taped recordings of interviews is problematic although in this case the questions were standardised, asked of everyone, with the opportunity to

probe and explore with the informant. Informant answers were read and re-read line by line for themes and categorised examples of this data can be found in the chapter on the findings and in the relevant appendices (see 1,2 and 3) in the form of direct quotations (Too, 1996). The interview data revealed the informant’s thoughts feelings and often their experience and so helped the researcher to gain insights into their lived experiences (Rose, 1994). The advantages and disadvantages of interviewing are summarised in table 4:-

Table 4

| |
|---|
| <p>Advantages of Interviews:-</p> <ul style="list-style-type: none"> • Response rate is usually higher • Responses can be gained from a wide variety of individuals • Most of the data is usable • Interviews provide rich or thick data • Probing and in-depth responses can be gained • The informant can tell their own stories, in the way they choose • Data is immediately available • More qualitative data can be explored in comparison to questionnaires • The interviewer can control the situation and reduce misunderstanding or missed questions, plus explore further to encourage the information to give complete and accurate answers |
| <p>Disadvantages of Interviews:-</p> <ul style="list-style-type: none"> • Interviewing is a highly skilled activity which requires careful training and practice • It is time consuming and costly to carry out • Informants can be influenced by the interviewer status, characteristics or behaviour • There is a danger of the informant providing ‘socially acceptable’ answers • Informants can feel put on the spot, tested or worry that they will ‘look a fool’ if they answer completely honestly • Informants may not answer the questions, be reticent or are not used to expressing their thoughts and feelings |

Burns and Groves (1995); Polit and Hungler (1991); Rose (1994); Fielding (1994); Hardy and Mulhall (1994); Morse and Field (1996); Rees (1997).

Fielding (1994) identifies a number of problems associated with interviewing; respondents rationalise situations or choices by explaining in emotional or illogical terms, which at first appear logical and reasoned. Respondents can also sometimes appear over polite, eager to impress, or try to anticipate the questions and answer what they feel the interviewer wants to hear. The above problems can cast doubt on the validity of the data and must be avoided. Oppenheim (1992) suggests that the interviewer must develop good interviewing skills, that it is probably the, if not the most important of skills to develop. Practising with the audiotape and testing out the equipment, rehearsing the questions, modulating the voice projection and having an interview guide can help overcome some of the pitfalls and difficulties (McKie, 1996). Barker (1996) suggests the use of an acronym S-O-L-E-R, which focuses the interviewer's attention to the interpersonal nature of the interview. This prompt will enhance the establishment and maintain rapport with the interviewee.

Table 5: Interpersonal Prompt for Interviewer

| |
|--|
| S-it to the side of the respondent facing in |
| O-pen posture |
| L-ean forwards slightly to indicate active listening |
| E-ye contact |
| R-elax. |

The interview schedules (for the three groups of interviews, for the three HoM's and the two senior profile midwives) can be found in appendices 5, 6 and 7. The simple yet effective aide memoir worked well for the researcher, each of the respondents relaxing into the in-depth interviews and the researcher checking that they were clear about the questions and their responses.

3.3 Data Analysis

Considerable thought should be given to this subject before embarking on the study. Data Analysis must take place during data collection. The process must be systematic, organised, moving the researcher from pages and pages of pure description to

manageable elements, themes or categories which tell a story or produce a set of findings that answer the original research question (Bogden and Biklen, 1982).

Qualitative data analysis traditionally entails the organisation of data into categories and themes, with their subsequent integration into an overall structure explaining the relationships and patterns inherent in the phenomena under investigation.

Although there are no systematic rules or formulas according to which the novice analyst may proceed, a number of steps are generally recommended (Dey, 1993, Huberman & Huberman and Miles, 1994, Janesick, 1994, Polit and Hungler, 1995, Clarke, 1999):

- collected data is read meticulously and reread so that the interviewer is thoroughly sensitised to the material;
- the actual words and phrases used by informants are coded according to meaning, and through this process a number of categories are developed;
- themes emerging from the data are found by examining and grouping these categories;
- the researcher searches for patterns and relationships linking the emerging themes;
- the researcher constructs an integrated depiction of these patterns and relationships;

An iterative approach to content analysis, as suggested by Polit and Hungler (1995), was adopted. The material was read and re-read closely, and coded for categories; an examination and grouping of these categories produced a number of themes; with these themes in mind, the researcher then went back to the material, searching for further/alternative categories and/or themes. This process was repeated until the results were felt to be saturated. A selection of transcripts and their corresponding categories and themes were checked by an independent reader, who had both midwifery and academic qualifications and experience. It was hoped that this combination of academic and peer review would help keep researcher bias and subjectivity to a minimum (Huberman and Miles, 1994, Polit and Hungler, 1995).

At first the task appears onerous and complicated as with this study. Enormous amounts of field notes were generated. First and foremost it was important to

undertake the analysis as the data was being collected at each stage of the collection process. More data was collected than was used, a common failing of inexperienced researchers (Morse and Field, 1996).

Qualitative research methods have often come under criticism for the subjective nature of data collection and analysis (Easton, et al 2000). Several authors including (Barbour, 2001; Cutcliffe and McKenna, 1999, 2002, 2004; and Cutcliffe and Goward, 2000), write extensively on establishing and maintaining methodological rigour throughout the qualitative research process. It remains however a contested issue (Cutcliffe and McKenna 2004). Melia (1997) claims that 'slight of hand' produces themes and that the reader is invited to take on trust, that theory somehow emerges from the data without being offered a step by step explanation. Other researchers advocate using greater detail in the methods section and include examples of the process of analysis (Cutcliffe and McKenna, 2002; Seale, 1999; Morse, 1994b and 1999b). Qualitative research does not use standardised procedures for data analysis however, in an effort to enhance the rigour and therefore the quality of the research, checklists have been developed providing the researchers with an aide-memoire (Seale, 1999). Barbour, (2001) cautions researchers about using these 'technical fixes' or checklists too prescriptively, as the checklist itself can strengthen the rigour only if embedded in the broader understanding of the design for data analysis of qualitative research.

As stated earlier, extensive data was generated from this study, therefore it was important that the accuracy of such a study should not be in question. Attention to detail is paramount (Strauss and Corbin, 1994; Schwandt, 1996:59). In this study the researcher was also the interviewer and transcriber, so errors in the transcriptions were unlikely to occur. However, commitment to accuracy at each phase is essential to the integrity of the study and necessary for establishing dependability and confirmability. The audiotapes were patiently listened to many times to ensure that punctuation, question marks, pauses and commas were put in the right place, as when placed incorrectly they can change the meaning or inference. Italics and exclamation marks were used, as they are heard on the tape to ensure not just trustworthiness of the process but also in establishing a high degree of methodological confidence (Lincoln and Guba, 1985).

3.4 Ethical Approval and Considerations

Ethical approval was sought at the research proposal stage from the then Chief Executive Officer of the Avon and Gloucestershire College of Health and the research was approved. Care was taken to provide informed consent, confidentiality and anonymity for the informants in this study (Rees, 1997). The interview data from the three HoM's and seven core grade midwives was coded for identification, transcribed coded, categorised and the tapes subsequently destroyed. Material generated from the policy-making midwives in key positions was transcribed from the notes taken, coded and categorised.

Respect for individual autonomy requires that informants are fully aware of the purpose of the study and have full details of what their participation will entail.

Participation must be on a purely voluntary basis and they must be given the opportunity to check any information they disclose. In keeping with this principle, potential informants were sent a brief outline of the study and a letter explaining what the process would entail. They were informed that the researcher is a practising Midwife Educator, that participation was entirely voluntary and that the study could be left at any time. After interview, informants were sent a transcript for verification and further comment. It was felt that the issue of informed consent were addressed by these means: although the researcher's emphasis might change over the process of the study, as is normal with qualitative research, the way in which disclosed information would be treated would not alter substantially. The researcher was scrupulous in ensuring that no details, which could identify any participant, were included in the presentation of the study.

It should not be possible to identify individuals or where they work from any of the findings (Rees, 1997).

3.5 Evaluation of the Research Process

Research findings only have value if the study has been conducted with appropriate rigour. Key concepts traditionally applied in this regard are reliability and validity, that is, the degree to which the tool of data collection consistently provides accurate results with regard to the phenomenon being studied (Rees, 1997). These criteria are, however, only applicable where the researcher is appraising something objectively, as is usual in quantitative studies, for example, taking a physical measurement, or processing questionnaires which require respondents to select pre-determined answers.

Qualitative research, on the other hand, is by its very nature a construct resulting from a combination of subjective experience and objective reality, dealing as it often does with people's perceptions, emotions and thought processes (including the researcher's) (Holloway and Wheeler, 1996). It therefore becomes meaningless to apply the above criteria, since the subjective element significantly alters the created construct, with findings consequently varying from researcher to researcher, or even with the same researcher, from one occasion to another (Guba and Lincoln, 1989, Streubert and Carpenter, 1995).

There is thus an obvious need to apply different criteria when evaluating qualitative research. The concept now considered a standard in the field is trustworthiness (Guba and Lincoln, 1989).

“Trustworthiness exists when the findings of a qualitative study represent reality”.

(Holloway and Wheeler, 1996: 92)

Guba and Lincoln proposed four criteria that a qualitative study needs to meet to be trustworthy. These are credibility, transferability, dependability and confirmability. Some writers in the field refer to credibility, fittingness, auditability and confirmability (LoBiondo-Wood and Haber, 1994); however, the use of different terminology does not alter the basic requirements needed for a study to be trustworthy.

Credibility requires the accurate representation of data: the researcher must therefore be capable of understanding the culture being studied, and of discriminating between relevant and irrelevant information. Guba and Lincoln (1989) recommend the researcher's "prolonged engagement" with, and "persistent observation" of, the culture under scrutiny. Involving informants in data verification, or "member checks", can also promote credibility. "Peer debriefing" is also recommended, whereby the researcher checks findings and analysis with a colleague as the study progresses, this the researcher undertook.

In this study, the researcher was a member of the culture being scrutinised, and therefore thoroughly conversant with it but being familiar with the culture and the professionals involved in this study was a mixed blessing. Whilst recognising that the knowledge of the cultural language and structure was a strength, the researcher was also aware that her own status and professional standing could influence the participant's responses. Therefore, ensuring that informants were not coerced to join the study, by stressing that their participation was purely voluntary and that they could withdraw at any stage was a very important feature of the research. Data was taped, and then transcribed and presented verbatim; transcripts were sent to the informants for verification and comment. An academic with midwifery qualifications and experience was asked to check the analysis and findings over a selection of the transcripts; she was in agreement with the researcher's interpretation of the data and the findings. The discussions and debate however, which was generated by this colleague and her probing inquiry, helped the process of understanding the data, its meaning and whether it was situated in the most appropriate category.

Qualitative research aims to understand phenomena, rather than to predict and control outcomes, so is not designed for the generalisation of findings from the sample to the wider population. However, transferability implies that the understanding and insights gained from a study may be applied to similar situations (Streubert and Carpenter, 1995). Transferability is not determined by the researcher, but by the readers of the research. The researcher needs to supply a comprehensive picture of the sample and context of the study so that readers can decide whether the findings are transferable for their purposes or not (Guba and Lincoln, 1989, Holloway and Wheeler, 1996). To

satisfy this criterion, a detailed picture of the sample and the sampling and data collection methods has been presented.

For a study to be dependable, it must perforce be credible, that is, have credible findings. The onus is on the researcher to show that the process of arriving at the findings is stable over time. This infers that the researcher must make explicit the rationale for the theoretical stance underpinning the study, as well as for the choice of methodology and analysis (Guba and Lincoln, 1989, Holloway and Wheeler, 1996). In this study, the researcher has attempted to explain the importance to the profession and to the NHS organisation of the topic under exploration; the reasons for adopting the research methodology employed utilising elements of grounded theory analysis and data interpretation have been explicitly stated, and the data analysis has been conducted in accordance with the principles governing this methodology.

Confirmability requires that it is possible to link the findings with the raw data. The reader should be able to follow the activities and thought processes which have guided the analysis and interpretation of the data, as well as the development of the conclusions drawn from it (Guba and Lincoln, 1989, Streubert and Carpenter, 1995). This “decision trail” is crucial to confirmability: sufficient information should be provided about how data has been collected and analysed, what decisions have been taken during this process, and why (Holloway and Wheeler, 1996, Clark, 1999). In this dissertation, an attempt has been made to present a clear “decision trail” by making explicit the process which has led from the raw data to the findings: a detailed account of the analysis process has been presented, illustrated by specific examples drawn from the interview transcripts.

3.6 Summary

The researcher has explained the rationale behind the construction of the research study. The justification of the method used has been explored in some detail.

The procedures of the data collection have been described, the planning process for the interviews. An overview of the data analysis process has been given and the research findings will be discussed in detail in the next chapter

CHAPTER 4

Research Findings from the Interviews

4.1 Introduction

This chapter reports the findings from the three phases of the interviews, firstly the three HoM's, secondly the two key midwives with a national profile and thirdly the rank and file midwives E, F and G grades. The interview schedules are included in appendices 5, 6, and 7.

4.2 Phase I

Table 6 Heads of Midwifery Details (in response to questions 1 and 3 of the interview schedule, appendix 5)

| Head of Midwifery | Situation | Number of Years in Post |
|-------------------|--|---|
| HoM 1 | West of England Large maternity unit 4,000 deliveries per year | 7 year Anticipating retirement within the next year |
| HoM 2 | West of England Large maternity unit 5,000 deliveries per year | 2 months Recently moved from a smaller NHS Trust |
| HoM 3 | West Midlands Medium sized maternity unit 2,500 – 3,000 deliveries per year | 8 years Well established |

The findings are reported under the themes that emerged from the interview data during the analysis process collected from the three Heads of Midwifery.

4.2(i) Theme: Career Biography (arose from question 2)

Two out of the three HoM's had made deliberate career moves into managerial positions. One moved from midwifery education into a clinical manager's role looking

for a different career direction. They both had undertaken further study which gave them the confidence to apply for senior manager positions. The third interviewee was sought out by a senior manager and encouraged to apply, even though she felt she had not been qualified long enough. She was appointed to her first 'G' grade (Sister) role. A period abroad and into project work she finally believed she could aspire to a job in leadership.

“I felt management was perhaps my forte, I could organise people”.

HoM (1)

So all three reported that they needed to feel confident in their abilities before making steps in their career pathways. What made them feel confident differed. HoM (1) expressed the need to have had sufficient experience before moving on or applying for a higher post. She felt her varied experience had prepared her for a role in management. HoM (2) professed no interest in promotion into managerial roles but felt bereft of options. She had explored a complete change of career and whilst deciding she commenced a higher education degree in the Arts. HoM (3) was far more focussed and says she planned her career moves. In addition, she undertook further study at university to give her confidence to apply for promotion.

4.2(ii) Theme: Career Aspirations in Relationship to Leadership (in response to questions 4, 5 and 6

Two out of the three HoM's interviewees stated that they thought that their career was largely opportunistic. Opportunities had arisen to act-up for their immediate manager or projects had been offered to the individual. From these opportunities HoM (2) reflected on the fact that she was happy with her role and practice but after a short acting-up experience saw the wider picture:-

“I saw the whole picture if you like, for the whole unit and that there were various things going on and I think when you are a clinical midwife there is a tendency to just see what you do and think that's the norm and not really see the variations [sic] in different types of practice and so to me, management meant being able to influence on a wider scale”.

All three HoM's viewed their own HoM career opportunities very positively. However, all three agreed that they had had no real role models, although their immediate manager influenced them or actively encouraged them in their decision to apply for promotion.

4.2(iii) Theme: Professional Leadership and Management (in response to questions 7 and 8)

All three HoM's felt they could identify individual midwives who could potentially aspire to their role:-

“I recommended this midwife for the acting-up position – she has now moved on to a larger unit (as a manager). She was bright, quick and had potential”.

HoM (3)

and from HoM (2) an acknowledgement that potential successors need management development:-

“They would have to have a management development programme which would be tailor made, not just a general management development programme”.

and from HoM (1) a clear explanation of what is required in order to lead and manage:-

“Good people skills definitely and mine were sometimes lacking. You need a good sound base, a good financial brain”.

When asked about identifying a successor HoM (1) was more cautious about recognising someone in her team who could lead. At first she adamantly claimed that no, no she could not, then (reluctantly) she agreed, maybe one person.

The discussion points from these interviews will be explored further in chapter five.

4.2(iv) Theme: Local availability of resources (in response to questions 8 and 9)

One of the concerns from the literature review about leadership and the preparation of employees for succession planning is the lack of financial or human resources locally.

“We don’t succession plan. It’s not managed, it happens. There is a need for a fast track”

HoM (2).

Issues of funding for study days, courses or longer taught courses in the service presents managers with serious concerns as mandatory updating sessions for all midwives takes up the majority of the staff development budget and time.

“ [There is] some management development for the existing ‘G’ grades. I am not that optimistic”.

HoM (3)

4.2(v) Theme: Formal Continuing Professional Development (in response to questions 8 and 9)

Links with HEI’s have encouraged a more formal approach to staff development by the contract formulated between the HEI and the then Consortium, now Workforce Development Confederation (WDC). Considerable financial resources have been invested by the NHS with individual Trusts bidding for credits for their staff to attend programmes, but again, much of the contracting is around clinical skills development rather than leadership or management.

All three HoM’s acknowledged that individual NHS Trusts have development programmes around managerial and leadership subjects, usually for midwives at ‘G’ grade and above, but at the time of those interviews 1998, 1999, little was available.

The researcher’s examination of documentary evidence from the Trusts found that the development programmes primarily centred on clinical courses eg. specialist courses for specific clinical areas or more generic courses such as teaching and assessing in practice.

4.3 Phase 2

The next phase of the research was to interview two senior midwives with a national profile. The interview schedule is found in appendix 6.

The purpose of interviewing two senior midwives with a national profile was to obtain their perceptions on the main questions surrounding this research study. Neither of the interviewees wished the interviews to be tape recorded therefore their responses were documented in field notes written by the researcher.

The two senior midwives examined the questions posed from their own personal views and from within the context they were working. Both midwives commented on the huge variety of HoM's roles, particularly that no two roles would appear to have the same job description. Variations exist from those who are employed at 'H' grade and still have a caseload of clients to those who are employed at clinical director level, with a large complex maternity service.

“Some units that they visit have the most senior midwife at only 'H' grade, which I feel is too low, these managers are often too busy and challenged with no role models and are counted as 'hands-on' staff”.

Senior Midwife

Or in some cases this senior midwife knows of some HoM's who are appointed and cannot or will not move on, the (maternity) service 'ticks over' and she believes client needs are not being met. They happen (HoM's) to be promoted but do not move the service on. Midwives under this style of leader, see no future for themselves, so if they are able, will move on, thus the maternity services may be losing potential leaders because of the current incumbent.

Both senior midwives agreed that the relationship fostered between the HoM and Head of Nursing is key to smooth working and it helps if that relationship is based on trust and equity.

Again, both senior midwives were concerned that midwives do not necessarily see good role models in leadership roles. One of the key midwives was particularly concerned about the calibre of the next generation of leaders, especially where statutory midwifery supervision was concerned and where that 'know how' was going to come from in the future, as the majority of existing HoM's are likely to retire within the next three to five years. Senior midwife (2) confirmed that she too believed that HoM's who demonstrate initiative and are pro-active and who come to be known in the NHS Trust as such, are given additional responsibilities or specific projects, thus increasing their knowledge and skills in the wider arena of management or leadership in the NHS. This however, can be counter productive for the maternity services as it takes the HoM away from her substantive role.

Both senior midwives agreed that HoM's once in positions of influence, are effective and efficient in those roles. More recently, the statutory body and the Department of Health have collaborated with the Chief Nursing Officer to provide a national initiative, a NHS midwifery leadership programme to encourage HoM's into strategic leadership positions.

The two senior midwives also confirmed that whilst both of them were concerned about the state of professional leadership in midwifery they also were aware that the concept of succession planning was not a high priority in most NHS Trusts.

Lastly, both agreed that something needed to be done about the looming crises if not by the NHS, then the professional body or the profession itself should be looking to improve its lot and indeed, should champion leadership and succession planning development.

4.4 Phase 3

As management in the maternity services is mediated through the views of the midwives it was necessary, indeed expeditious to capture the views and perceptions of the core grade midwives working on the 'shop floor' in the NHS organisation. Using the themes generated from the three HoM's interviews, the researcher constructed a semi-structured interview questionnaire for the core grade midwives using the same

themes that were previously generated, career biography; career aspirations in relationship to leadership; local availability of resources; formal CPD opportunities; professional leadership and management (see appendix 7).

Qualitative studies focus on the human experiences and the reality of a situation in the person's natural environment. In an effort to understand more fully if midwives themselves could identify themselves as having either the opportunity to develop the potential to lead or that they themselves have been encouraged by someone in their own Trust to apply for promotion.

The results from the interviews conducted will be presented in the form of comments and statements from the respondents. The researcher's aim was to find out from the informants, their feelings and point of view rather than that from the researcher herself. The interview data was also used to corroborate the themes generated.

In any analysis of interview data there is a problem of unusable data. Ideally, it all should be accounted for under theme or sub theme and codes, (Glaser and Strauss, 1967 p23). This, however, is not always possible, this unusable data is referred to as "dross" (Field and Morse, 1985 p 113). In order to illustrate how themes emerged see appendices 1, 2 and 3. Information that was not included tended to be more personal or less representative overall.

Although the sample size is usually small in this technique, in this sample the total was seven. Comprising:-

Two 'E' Grade midwives

Two 'F' Grade midwives

Three 'G' Grade midwives.

For employment purposes there are three grades of midwives in the NHS.

'E' grade midwives are the basic grade of midwife and are appointed to this grade when newly qualified. They are competent as a midwife at the point of qualification and normally spend one to two years in this grade, gaining confidence in their knowledge and skills and developing their expertise.

'F' grade midwives are appointed to this grade. It is a promotion. Midwives at 'E' grade who are experienced and meet the job specification requirements can apply for this promotion.

'G' grade midwives are the most experienced midwives who, in lay persons terms, would be described as the Ward Sister or if practising in the community, the Community Sister. Staff are promoted into this position.

The sample was a purposeful sample, in that an open invitation to midwives to participate in the research was offered via the Trusts in the north of the South West region of England and these seven midwives accepted.

Although smaller size samples reduce how much can be generalised from the results, it must be recognised that this was not necessarily the purpose of the study. Rather, that the aim was to identify the informant's concerns and experiences in order that these may be recognised as issues to be addressed.

It was fortunate that the sample was comprised of the three levels or grades of midwives. Indeed, it took quite some time to interview the second 'F' Grade midwife. The researcher was concerned that without a comparison to the original 'F' grade interviewed, it would not give the study sufficient breadth from a key grade of midwife. Therefore both the second, 'F' grade and third, 'G' grade were interviewed at the end stage of the field work phase of data collection.

4.4(i) Theme: Career Biography

Midwives enjoy talking about their careers particularly about the key stages in the development of their own lives and their career steps. All informants enthusiastically talked about how they had got into their current positions. Their ambitions, achievements and a sense of pride in their careers so far, emerged from the data.

It is true that for those at the beginning of their careers their main concern was to consolidate the knowledge that they had gained from their training, as illustrated from the following quote:

“I wanted to qualify and gain some experience and decide what to do ... I wanted to gain confidence before deciding ...”(what to do next)

‘E’ Grade Midwife (1)

“I chose to come here. To gain confidence and consolidate ... Well at least to a second rotation. Career long term? Community, but this is first year to consolidate”

‘E’ Grade Midwife (2)

These comments concur with Frazer and Worth–Butler’s (1997) work when interviewing newly qualified midwives. They suggest that newly qualified midwives appeared to need to gain experience in a hospital setting to build up their confidence. Expecting students to consolidate their learning on registration poses certain problems. Firstly, not all midwives get jobs immediately with some managerial resistance to employing newly qualified staff. Secondly, current staffing policies make it difficult to provide and maintain effective preceptorship programmes because of lack of permanent staff on units and an ever increasing trend for Trusts to employ newly qualified staff initially on temporary contracts (Veitch et al, 1997). The ‘E’ Grades in this study were complimentary of a system of ‘buddying’ that was running for all new staff in one of the Trusts. Each new member of staff was linked with a ‘G’ Grade midwife who would ‘ease’ their passage into the trust and ‘show them the ropes’.

Once midwives are established in a role a different picture emerged. Confident in themselves as people and as professionals as they express themselves:-

‘..... Why midwifery? Well I will go back many, many years ago, to school. I was at school in the 60’s and 70’s. Now midwifery was always something that interested me but it wasn’t a job for a boy to do so I started nursing, I did mental handicap nursing for three years, but I was still half empty I wanted to do my general (nursing). I went on to do that and the light was

getting closer to midwifery and hence I applied and here I am, been qualified, er gosh, almost seven years'

'What is your ultimate goal?' (interviewer)

'My ultimate goal is teaching'.

'F' Grade Midwife (2)

and from another successful midwife:

" So I would say that my career to date has progressed very well. Where I am going in the future is hard because I have already achieved in 5-6 years what I thought might take me 10!"

'G' Grade Midwife (2)

Why do you think you got on so well in the past? (Interviewer)

"I think a couple of reasons. I had a life, a career before midwifery and so a lot of my skills were transferable and .. eh .. that obviously had a huge part to play, but the other thing is that I have absolutely maximised every opportunity that's been, you know, even a remote possibility, I've been quite 'pushy' as well."

'G' Grade Midwife (2)

This midwife goes on to elaborate on how she tackled managers, pushing them to give her the clinical experience she felt she needed in order to become a 'G' Grade midwife.

All three 'G' Grade midwives made similar comments about pushing themselves to obtain clinical experience or further funded courses.

"Yes, there's been opportunity, again it tends to be self-motivated as opposed to prompted by my line manager"

'G' Grade Midwife (1)

"I think you're the one to seek it. Rather than it being presented to you"

Both 'F' grade midwives considered themselves as reasonably satisfied with their career progress thus far however, both admitted to being frustrated at the lack of opportunity as they perceive it, in being considered for promotion or obtaining funding for further career development. Both 'F' grade midwives have recently funded themselves in order to undertake further study and thus fulfil their aspirations.

4.4(ii) Theme: Career Aspirations in Relationship to Leadership

When midwives went on to reflect upon their career aspirations and whether they contemplated a leadership or management position, several issues arose.

All of those midwives interviewed could see a future in the midwifery profession. Even the two newly qualified midwives viewed their future positively and although it was not possible to encourage them to take a very long-term view, they both had professional goals to achieve within the next three to five years.

'Career long term? Community, but this first year is to consolidatethat's where I see myself, we explored our careers in training but you can only see to the end of the course'.

'E' Grade Midwife (1)

'Yes, originally as a student I wanted the community it's not my thingat allI want to work in the Neonatal Intensive Care Unit (NICU) and do a degree.

'E' Grade Midwife (2)

Constantly recurring in the data were the following factors:

- Organisational issues/barriers to their development were reported by all seven midwives
- The Human Resource Strategy of the Trusts which was not transparent to the midwives

- The Culture of Midwifery

Senior staff seemed to get more CPD opportunities, with some staff, particularly those lower grades, not having a voice and therefore little opportunity for development. These factors overlap considerably in the many issues examined and the structure of this chapter aims to bring out that complexity.

What becomes clear from the informants is the lack of information available to them. Unless they seek out the information, it becomes manifestly clear that posts and opportunities for further experience are not part of the organisation's Human Resource Strategy (HRM). Individual midwives career aspirations are not explicit or overt, indeed, even though there may be appraisal systems in place, unless the midwife clearly and loudly proclaims what she intends to do in the future, very little attention is paid to her career.

It appears from the interview data that the midwifery grades 'E' and 'F' are not foremost in the manager's mind when deciding who has staff development support.

This is an important organisational and HRM issue for Trusts, particularly as retention of staff is a key indicator in the present government's plan (A Health Service for all the Talents, 2000).

Two of the 'G' Grade midwives interviewed spoke about how investment in staff seemed to be directed at 'G' Grades and not the lower grades of midwives. This lack of planning of clear performance management is not helped by the lack of clarity between whose role is it and the lack of a consistent effort to build research and development findings into future workforce planning.

Concern has been expressed in the 'Talents' (2000) report about the lack of proper engagement by many senior NHS managers and policy makers of workforce issues.

4.4(iii) Theme: Local Availability of Resources

The ethic of 'service', was seen as fundamental to midwifery as a caring profession, largely composed of women. The nature of this ethic, and the respect accorded to those who upheld it, made it hard to challenge this service ethic or culture of midwifery, which emphasises and internalises the values of commitment caring irrespective of personal sacrifice.

From the newly qualified midwives who commented on:

'Yes, difficult to get on courses. It's there are problems for part-time staff

'E' Grade Midwife

'Time queuing up to go on courses..... (the) 997 has a waiting list'

'E' Grade Midwife

'There has been a problem with study leave. Um, in view of the decline in midwives (sic) and fast turnover of staff. To release midwives to go off and do study has been ... for me, a problem'

'F' Grade Midwife

and from the same 'F' Grade midwife a touch of humour:

'So I will be 60 before I am finished' (studying for a degree).

From these informants it was clear that Trusts do have a range of in-service courses available for staff usually associated with compulsory or mandatory training. All the respondents stated that whilst they would agree courses and indeed opportunities were available to them, the organisation of such courses and similar opportunities is haphazard. Several pointed out that they must rely on themselves to find out what is available, rather than be singled out or directed to apply.

As one 'G' Grade midwife puts it: 'You are the one to seek it, be proactive and find the resources. People don't understand the funding, how much or the mechanisms for accessing the funds. Its not actively publicised. Managers don't push people forward. People are not given the belief that they can be the next leader or manager'.

And finally a comment that comes through in the data that Trusts are very poor at developing 'E' and 'F' grade midwives beyond the mandatory training.

Attention to career advice seems to be lacking with only one of the midwives acknowledging that she seeks out others to help her focus on career direction.

4.4(iv) Theme: Formal Continuing Professional Development (CPD)

Opportunity to go on courses outside of the Trust, (ie. Higher Education) is available with most Trusts linked into the formal arrangements provided by the Education Purchasing Consortium (EPC). This involves individual Trusts purchasing academic credit from the HEI's that the consortium has a contractual agreement with. This includes the agreed price and credit value per module of learning. The mechanism of enrolment onto these modules which make up the course can be torturous!

Individual Trusts decide which modules they will purchase, then the Trust has to encourage staff to apply for the courses. This part of the purchasing is handled very differently in each Trust. How midwives in practice find out what is available or desirable for them to study seems to be left to chance.

Table 7 was constructed to demonstrate the 'G' grade informant's responses to the third question asked at interview, 'What learning opportunities have been available to progress your career and what type of courses? The core theme, Formal Continuing Professional Development emerged and as the table displays, so did a number of sub-themes which developed the findings further.

Table 7 **Example of a core theme & sub-themes emerging from the three ‘G’ grade midwife informants**

| Core Theme | Sub-themes | Code | Researchers Notes |
|---|--|-----------------|---|
| Formal Continuing Professional Development | Bias towards NHS Trust in-service training (i) | Ins i | In-service i, ii, iii |
| | Trust in-service workshops for compulsory training eg. mandatory skills, emergency drills (ii) | Ins ii | |
| | In-service days well supported (iii) | Ins iii | Career moves planned 1 (all 3) |
| | Poor communication about what is available and how to access the relevant information | Access Info 1 | Access info 1 – Needs 1 & Fund 1 & Leave 1 |
| | Courses offer not matched to midwives needs/interests | Needs 1 | Seek and negotiate 1 (proactive) |
| | Funding Issues | Fund 1 | |
| | Study Leave difficult to organise | Leave 1 | |
| | Negotiation of a career break x 1 participant | Career Break 1 | NB: All 3 informants had undertaken further CPD activity self-funded & organised outside duties in HEI's |
| | Planned career moves, all three informants | Moves Planned 1 | |
| | Self-motivation is necessary | Motiv 1 | |
| | Can be linked into their annual review and supervisory interviews | Linked 1 | |
| | Find out what is available and go and negotiate with your manager | Seek1 | Self Motivated |

From the data collected and analysed, the midwives generally know that courses are available. The actual mechanics of how to apply and what exactly is available to them, other than the Trust specific in-service training on mandatory updating skills, is less clear and very much dependent on the midwives finding out for themselves.

When asked specifically ‘who would you ask for advice about CPD?’ the informant’s reply:

'Manager or Supervisor'

'E' Grade Midwife (1)

'If you want more information see a manager'

'F' Grade Midwife (1)

'Usually using your annual appraisal to discuss where you felt you wanted to pick up on things'

'F' Grade Midwife (1)

One midwife reported that he had noticed a difference between the amount of help/support between major maternity units and the smaller peripheral maternity units.

'They (the smaller maternity units) have the course fees, travel and time, paid for by the Trust. We have to fight' (in the major maternity units).

'F' Grade Midwife (2)

In conclusion, it is clear that most informants are really unsure as to what the procedure is for applying for courses. But a more fundamental issue is that midwives would appear to not know what is available, other than from advertisements in professional journals or from Trust noticeboards. The link between yearly appraisal or annual statutory midwifery supervisory reviews and formal C.P.D. opportunities and actually accessing information for courses seems not to be organised but rather haphazard. If the midwife champions herself and is 'pushy' she may achieve at least a place on a course. She still however, has to negotiate study leave and funding. Other forms of 'opportunity' such as job swap, secondment and 'acting-up' which did not involve undertaking courses did not feature in the informants responses. This lack of advice regarding professional development and career pathways concurs with Sheperd's (1995) study of qualified nurses.

4.4(v) Theme: Professional Leadership and Management

When discussing issues concerning leadership and management, the association was usually made with a positive reference, whether to the personal traits of an individual or to the position they held within the organisation.

One informant made a very strong association between leadership and statutory midwifery supervision this is not necessarily the case for all midwives or indeed midwife supervisors. At this juncture it is necessary to inform the reader that statutory midwifery supervision is not related to management. Supervision has been a statutory

obligation for over 100 years, but it is only in very recent years that it has had any real meaning for the majority of practising midwives. The purpose of the statutory supervision of midwives is to protect the public and to support and promote good, safe midwifery practice. In fulfilling this remit, supervision plays a critical role in developing midwifery practice, leading the profession and developing the standards and policies to ensure the safe, high quality of the service. The Supervisor of Midwives has an important role in ensuring that all midwives are fit to practise to the level of autonomy commensurate with an autonomous practitioner at the point of qualification, without referring to a medical doctor. Midwives are authorised by law to carry full responsibility for mothers and their babies throughout antenatal, intranatal and postnatal periods, unless there is an emergency or deviation from the norm, which is outside their sphere of practice. Supervisors are responsible for initiating action when a midwife's fitness to practice is impaired. It is vital that midwives are competent to assume the full responsibility of the role and are able to maintain and develop their skills, knowledge and competence. Statutory supervision can help midwives to achieve this.

'I think supervision is about crafting the profession, about crafting midwifery'

'G' Grade Midwife (3)

This link with supervision did not appear in the other informant's transcriptions, other than to mention the supervisory annual review meeting as identifying midwives individual clinical updating.

All informants could differentiate between management and leadership and most were very clear about the attributes that are required to be either an effective leader or efficient manager.

On management;

'Business orientated, scheduling, strategic planning, knowledge of the service'

'F' Grade Midwife (2)

Some informants thought they could identify midwives with potential and stressed that they would positively encourage protégés as can be seen from the following comment by a 'G' grade midwife;

'If I saw potential, that I could acknowledge it (then) that's a sure way to assist promotion'

'G' Grade Midwife (1)

and went on to give an illustration.

'I encouraged my 'F' grade in the team, I don't think, without my encouragement she would not have gone for it (promotion).'

'G' Grade Midwife (1)

From the newly qualified midwives a slightly cynical perspective of leaders and or managers emerged. They gave examples of the qualities they had seen of arrogance, confidence, speaking up for us, even if we did not want it and that leaders are self selecting. Some interesting perceptions expressed here but of course these may not be generalised to the population of 'E' Grade midwives.

'Managers have to have the ability to respond flexibly and be able to change accordingly. I think its gone from the days of being able to do, traditionally to stay in one role. You have to be all listening and all adaptable and respond very quickly ... (sic) You have to be able to communicate incredibly well'

'G' Grade Midwife (3)

and on leadership;

'I think you need to be more present yourself, be innovative in your midwifery styles, be able to stand up and treated (sic) as an equal, assertive skills, and today this can be lacking in management'.

'G' Grade Midwife (3)

She went on to express the necessity for role models as managers and leaders. Several of the informants mentioned the need for professional leaders and indeed managers to be well educated, assertive in order to stand their ground and also to present themselves well.

Informants also reflected on the negative aspects of leadership and management that they had experienced in their careers:

'The 'G' Grades here are not good role models'

'E' Grade Midwives

A final consideration from the informants was the concept that leaders emerge at different levels in the maternity service which begs the question as to how the maternity service will firstly, identify these potential leaders and secondly, develop them.

Considering the governments drive to ensure that the NHS recruits suitable and sufficiently trained staff at both graduate and undergraduate levels, retention strategies should include training and staff development strategies. Overall workforce planning and development is not embedded in the culture of the NHS particularly at the lower levels of staffing the support staff and the lower grades of professionally qualified staff, including 'E' and 'F' Grade midwives.

In conclusion, this chapter has examined in detail the interviews with the midwives who provide day to day care for mothers and babies. The informants were able to describe in great detail their career and personal aspirations and were clear about the problems associated with accessing or continuing their studies, their hopes for their future and the future of the maternity service in the NHS. However, the Service is not necessarily putting them at the centre of care or development and looking at the documentary evidence from the Trusts it seemed that not much was being provided above the mandatory/in-service requirements in order to function in the role.

The next chapter will discuss the findings in more detail and apply them in a wider context.

CHAPTER 5

Discussion of the Research Findings

5.1 Discussion

This chapter is a discussion of the implications of the research data generated in this study. The discussion will be structured around the themes that emerged from the data and where appropriate, supporting literature. The implications of the findings for practice and recommendations for continuing professional development will be explored in this chapter.

5.2 Career Biography

The research findings in this category are interesting indeed. In Tucker's (1999) survey of HoM's, 72% of the respondents had been in post from one to nine years. The HoM's interviewed in this study were also experienced and this provided for the maternity services a level of stability which, it can be argued, is a positive feature. However, when a comparison is made with the age profile of the three informants, the findings indicate an ageing HoM workforce with one of them between the ages of 40-50 years and the other two between the ages of 50-54 years. Therefore two of these HoM's will be eligible to retire within the next five years. Nurses and Midwives can retire from service at 55 years of age, under Whitley Terms and Conditions.

Concern about the ageing workforce and the loss to the NHS organisation of its most experienced managers/leaders featured in the interviews with the two high profile midwives with both of them expressing concern about who would be left to lead the profession into the twenty-first century. It is also beginning to impact in the literature (Employing Nurses and Midwives 2001: Buchan, 2002). The July 2000 Health Service Circular on flexible retirement NHSE (2000) recognised the implications of ageing for the NHS workforce and has recommended flexible options such as winding down, stepping down, retiring or returning to practice (Watson et al, 2003; Dow, 2003). The NHS pension scheme which is flexible may encourage employers to

provide opportunities for experienced, mature practitioners to stay on at work albeit in a part-time capacity. This may in the short term reduce some of the problem.

Career prospects for nurses and midwives have improved since the introduction in the year 2000 of 232 Nurse Consultant posts, set to rise by 1,000 by 2004. The Consultant Nurse (Midwife) role advocated by the government DoH, (1999) is multi-faceted and has four core functions: Expert Practice, Professional Leadership and Consultancy, Education and Development and Practice and Service Development linked to research and evaluation. Liple (2001) suggests that good clinical leadership is central to the delivery of the NHS Plan (2000). The NHS requires leaders who can transform the service (Girvin, 1998; Bass and Avolio, 1994; Porter-O'Grady, 1992; Trofino, 1993). Consultants spend at least half their time working directly with patients, ensuring better and more convenient services. Moore (2001) states that the Consultant post represents a great step forward for the nursing and midwifery professions. Anecdotal evidence suggests that some are struggling to get to grips with the challenges that this role exerts, however, Moore (2001) writes that some consultants are proving themselves to be creative and innovative leaders who are shaping the NHS. Not that the newly qualified midwives in this study had given their own career steps much real thought, other than to consolidate and gain confidence in this their first post, this corroborating Frazer and Worth-Butlers, (1997) work. For the newly qualified midwives their role transition from student to neophyte midwife is their primary concern, surviving and consolidating that first year. Although one of the newly qualified midwives did proffer an answer that she was interested in working in the community as a Community Midwife.

'F' and 'G' Grade midwives once established in their roles presented a confident air, both in their professional and private lives. These midwives also articulated the view that they themselves were in charge of their own careers with both the 'F' and 'G' Grades having specific goals and ambitions which included comments such as

'scramble on and do a degree'

'F' grade midwife (2)

All three 'G' Grades were proud and enthusiastic about their careers thus far but all three were looking for new challenges

‘so, ok I’m at that stage of wanting to move on from the ‘G’ Grade and actually directly, probably implement new policy and change strategies, being both able to be in the University and clinical (setting).’

‘G’ Grade midwife (3)

In summary, for those Midwives interviewed career planning seems to be for those early in their careers, unplanned and opportunistic in nature. For those midwives who are confident and experienced, their career moves are planned.

Continuing professional development (CPD) is central to the NHS modernisation DOH (2000) the post registration education budget, under the non-medical education and training levy will rise by £1 million in 2002/3. The CPD contract will be examined further in the themes - local availability of resources and formal CPD activity opportunities. The contract relates to the formal arrangements between Higher Education Institutes and the local NHS Trusts via the local Workforce Development Confederations to provide (WDC) CPD courses for NHS staff (AGW 2004).

5.3 Career Aspirations in Relationship to Leadership

The three HoM’s originally interviewed could describe in some considerable detail how they had moved through their careers. One of them confirmed that she had not really aspired to leadership positions, she described her career pathway as opportunistic, being in the right place at the right time, whilst the other two had made deliberate career moves in order to establish themselves in leadership positions.

Midwives in this study were asked about their vision for the future which the majority viewed positively. Not all felt their future would be in leading or managing the profession but each expressed a genuine interest in furthering their careers.

The two ‘E’ grade midwives, had some ideas for pursuing their careers which would involve a strong clinical focus. One in the community practising as a domiciliary midwife and the other would be moving into a very specialised neonatal care role.

When probing further into their own perceptions of career pathways, it became obvious that NHS Trusts may be perceived as having little interest in their staff and their longer term career aspirations. Major input into national workforce planning exists but is not sufficient on its own. Local Workforce Development Confederations now established will co-ordinate the workforce plan on basic professional training for non-medical staff to plan post-basic professional training and other grades of staff training - this will include purchasing, monitoring and general commissioning of courses. The new confederations will also provide a focus for the development of human resource strategies which will encompass recruitment, retention of professional staff; reduction in wastage in training; rotation and secondment opportunities (DOH, 2000b).

In order to have increased effectiveness, preparation in leadership is an essential part of the professional's preparation for practice. When the individual understands the concepts and skills of leadership then the work environment and events should be efficiently lead (Moiden, 2002).

What also came across from the transcriptions of the interviews with the midwives interviewed was the issue of them saying 'It's not my turn' and the 'queuing' that appears to be evident in the Trusts or the 'pecking order'. This is symptomatic of midwifery culture Kirkham (1999), where seniority is ascribed in time slots and the further up the seniority ladder the more likely you are to be supported and allowed to undertake additional training etc.

The 'G' Grade midwives had noticed that the Trusts were poor at developing the 'E' and 'F' midwife Grades, very little investment was forthcoming, interviews with midwives at these grades confirmed this perception. Although, all midwives felt they had to be proactive in seeking out opportunities and as one 'G' Grade put it succinctly she 'maximised every opportunity and was pushy'. The others felt that there was not enough opportunity to explore new or expanding roles.

Mentorship is a concept familiar to most health care professionals (Morton-Cooper and Palmer, 1993:56). In a recent DOH/ENB (2001) circular it is recommended that service providers and Higher Education Institutes (HEI) should formalise the preparation support and feedback to mentors of student midwives. During training

students are assigned mentors who will oversee their skill development and record the student's progress in the competence log. Once qualified, in line with best practice, a preceptor is appointed to act as a point of expert contact for the newly qualified practitioner (UKCC, 1999). The role of the mentor is essentially one of guidance and support, as some would say, a wiser more experienced person (Hamilton, 1981).

Interestingly, none of the core grade midwives interviewed mentioned the LEO programme as a possible development opportunity for themselves. The researcher recently contacted (2003) the midwives in this study to ask if any of them had undertaken the LEO programme since being interviewed, one 'G' grade midwife confirmed that she had attended and she reported that she had found the programme stimulating and relevant to her role, thus affirming Werret, et al (2001); Gulland, (1998); and Cook, (2003) findings.

The midwives in this study also talked about having a special person or informal mentor that they could talk over their careers with. Those who were already some time into their careers, the two 'F' and three 'G' grades, were quite clear that they discussed their options with this 'mentor' if only to clarify their own thoughts about the decision. The two 'E' grade midwives were complimentary about the preceptorship and buddying model used by their employers to support newly qualified midwives but neither 'E' grade midwives had informal mentors.

Acting-up opportunities did not feature highly from any of the HoM informants, it was however mentioned by the 'G' grade midwives as an important vehicle for them to understand new and different roles (Sheperd, 1995).

5.4 Succession Planning

From the findings from the interviews it is clear that the NHS Trusts and indeed the NHS as an organisation does not have a co-ordinated approach to succession planning. Despite earlier attempts, including Opportunity (2000) for aspiring women managers to achieve promotion to Chief Executive level and the development of the Women's Unit at the DoH. The overall finding confirms that whilst there is some activity at national

level this does not necessarily permeate the many levels of organisation in the NHS Trusts.

Table 8

The Succession Planning Relationship
between the Midwives and the NHS Trusts

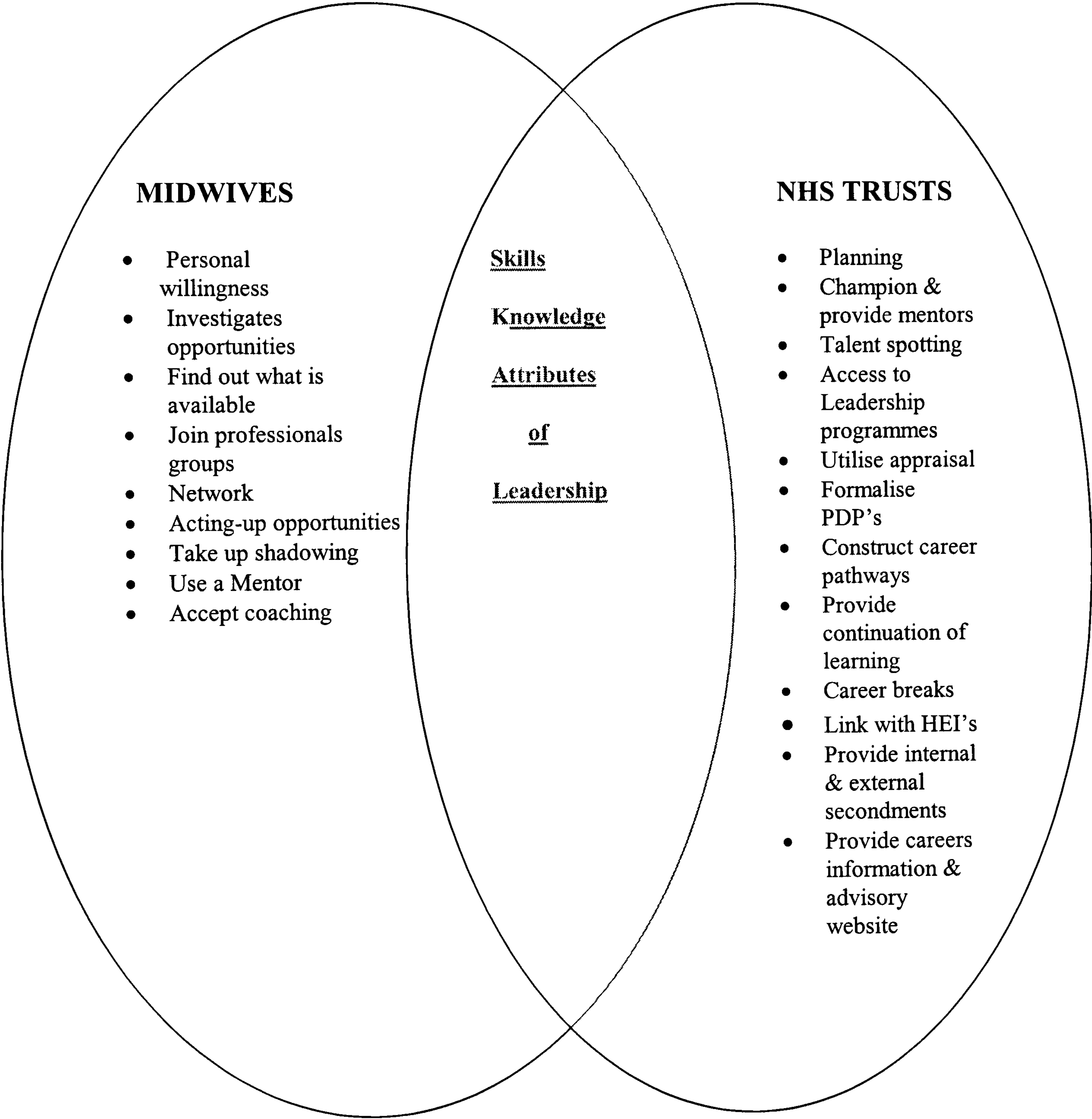


Table 8 in the Succession Planning section is the researcher’s attempt at bringing the midwives’ characteristics and opportunities and the NHS Trusts essential actions together. Where they overlap are the Key Skills of knowledge and attributes of

leadership which both parties need in order to develop the maternity services to embrace and implement change.

What was not evident in the interview data was the other forms of development which would create an enhancement of their roles. One of the 'G' grade midwives mentioned in passing that she had undertaken a job swap when a 'G' grade community midwife had requested an opportunity to update herself on the labour ward and they had exchanged roles for three months.

Creating different types of development which does not necessarily involve more expenditure would benefit the service greatly eg. undertaking project work, job exchanging, shadowing other midwives in different roles and secondment opportunities. Secondment has been used as a vehicle for staff development for some time in the NHS and is a very positive and popular development for senior staff. It was originally developed in the private and business sector to encourage the sharing of ideas and cross-fertilization of management, including leadership skills (Institute of Personnel Management, 1988). Early reports of secondment use in health care appeared in the mid to late 1980's (Morris, 1998; Greig, 1994; Stern et al, 1995a, 1995b, 1997), first at senior level and more recently across a number of professional groups (Rix and Jones, 1996) and in the last few years more commonplace in nursing (Hamilton and Wilkie, 2001), providing flexibility and diversity to the structure of many staff groups.

The ability for HoM's to talent spot and perhaps, identify their successor was reported by the informants. This fact is surprising as the NHS has not encouraged its leaders or managers to act as a talent scout for the organisation. The three HoM's could identify someone who had the potential to take over their role, they were also clear about the qualities that had influenced them in their decision-making. They looked for midwives with:

- existing management skills
- good communication
- dedication
- well qualified and knowledgeable

The HoM's also went on to elaborate on the methods they would use to assess the suitability of potential candidates for senior positions and these involved the following:-

- personal observation and contact
- the appraisal/performance review system
- work quality
- staff opinion and respect
- self comparison.

Succession planning is not reported in the health service literature very often in fact it is extremely rare (Fruth, 2003). However, with the introduction of positive action leadership programmes, which impact on the informant's ability to recognise and accept the responsibility for succession planning, (Cook, 2001; Fruth, 2003;), the situation should improve but will need to be monitored carefully.

5.5 Importance of Continuation of Learning

All of those midwives who were interviewed responded in the affirmative that there was Trust-based training for management activities but no-one mentioned leadership as a separate development from management study days or short courses.

The midwife informants however, stressed how difficult it was to access the information about these courses. They found it hard to obtain information about where such courses would be held and how they could apply for them. There appeared to be a large gap in available information for midwives as well as how to access about CPD activity. From the researcher's examination of documentary evidence from prospectuses and flyers for study days pinned to notice boards, there was obviously the possibility of accessing education activities. However, less evident were the contact names, telephone numbers or email addresses of those Trust staff who could help the midwives access these learning opportunities.

The HoM's indicated that they had had some acting-up experience prior to their current employment, however, none of the midwives had had this opportunity. Trust management courses were reported as either National Vocational Qualification (NVQ) based or other NHS Trust based programmes. Very few HoM's had had the opportunity to undertake University based management programmes such as leadership training, Masters in Business Administration (MBA) or similar. The midwives who were interviewed reported difficulties in accessing the information about courses and also reiterated the major problems of queuing, waiting lists and waiting for 'their turn'. The ever present staffing crisis often makes attending courses impossible and funding issues, such as travel expenses when the course is facilitated off Trust property, becomes an issue.

In defence of the NHS Trusts they are obliged to provide mandatory in-service training for all their staff groups in Health and Safety, Food Handling, Drug Administration and Manual Handling and latterly for the NICE guidelines. This means that an average size Trust is spending most of its education and training budget on keeping its existing employees up to date on those mandatory programmes, let alone the luxury of providing additional learning activities possibly off-site and very costly.

The midwives who were interviewed agreed this fact. They went on to express forcibly that they themselves have to seek out/find out what is available. There is no one point of contact or display board or printed information available to them. Trusts are large and may extend over several hospital sites, communication and information systems are poor or barely functional. As stated earlier in 5.2, career advice is lacking in the service, unless you have a mentor. Managers are perceived as not necessarily proactive in this sphere, from the evidence provided in this study they need to look further down into their own organisations to identify the potential leaders/managers of the future amongst those 'E' and 'F' Grades, who are not currently being developed. A strong recommendation from the research generated in this category is that Trusts must develop information systems that are efficient, transparent and complete, so that all employees are made aware of education and training opportunities both within and outside of the Trusts. The haphazard nature of educational opportunities that the midwives experience in this study should not be allowed to continue.

Midwives have for many years, like so many other professional groups, continued their own education (Pope et al, 1998). Many Nurses and Midwives are training at graduate level at the point of qualification. Therefore for those midwives who are certificated or hold diplomas, the necessity for the last 10 years has been to obtain a degree from their local University. Popular subjects have included Sociology, Psychology, Biology, Education and Nursing or Midwifery. Mostly those additional studies have been undertaken in the midwives own time, funded by themselves and generally not supported by the employer.

Since the early 1980's the link with HEI's to provide the pre-registration basic Nursing and Midwifery programmes (UKCC, 1986a) has been strengthened. This has further encouraged NHS Trusts to contract with their local Universities to provide commissioned programmes for Nurses and Midwives, usually jointly validated between the then English National Board (ENB), now NMC, and the University, for post qualification programmes. These commissioned courses are predominantly skills based programmes and are very much about the acquisition of new skills for a very specific area of clinical practice e.g. Renal Nursing or areas deemed 'high tech' such as, General Intensive Care, Coronary Care, Critical Care and Principles of Paediatric Cardiac Care.

The necessity for the Trusts to provide nurses and midwives capable of acquiring new clinical skills is essential due to the increasing number of specialities that are developing. Increasingly, nurses and midwives need to keep up to date with professional knowledge themselves in order to continue to be useful as an employee.

The majority of monies provided by the Workforce Development Confederation and distributed to the NHS Trusts is ringfenced for buying academic credits in three major clinical areas, highly technical skills courses, continuing care courses and lastly professional development programmes. The credit is not evenly distributed. The Trusts that purchase the credit therefore make the decisions regarding what post-qualification education nurses and midwives have the opportunity to undertake. Midwives report in the interviews that they have very little knowledge of what is available for them to enrol onto, and who to ask for help in finding courses relevant for their own professional needs. Midwives interviewed in this study did report that during

an appraisal review, some managers referred to CPD opportunities, but usually nothing was finalised. Midwives also reported similar conversations with their supervisor of midwives during an annual supervisory interview, but as supervisor of midwives are not budget holders it is unlikely that any recommendation for attendance at a course would necessarily result in the midwife undertaking the course. Therefore in summary, this theme reflects similar findings to 5.3. Midwives in this study are largely unaware of the processes existing in Trusts whereby they can find documentary evidence of courses available to them. They are also unaware of any one person who would have the knowledge to help them.

‘G’ Grade midwives report that they themselves seek out information from the managers. They report themselves as being ‘pushy’ and well motivated and capable of negotiating with managers to obtain either the funds or study leave or indeed both to attend courses. This however, may not be the case in all ‘G’ Grade midwives. ‘G’ Grades also reported that they have noticed very little investment in the other grades of midwives.

5.6 Qualities of a Professional Leader

The midwives interviewed in this study were quite clear about the qualities they sought in leaders.

Table 9

| | |
|------------------------------|--|
| Flexible | Well Educated |
| Stand their ground | Role Models |
| Have assertive skills | Are talent scouts |
| Can innovate | Are change agents and can manage change |

All informants could delineate between the terms managers and leaders. They were clear that manager’s skills included the following:-

Table 10

| | |
|-----------------------------|---------------------------------|
| Have business skills | Scheduling |
| Strategic Planning | Knowledge of the Service |

Some midwives felt that the two were complementary, but as one 'F' Grade stated:

'there aren't enough professional leaders with not so much vision but the courage to see it through, to stand up for the profession (SIC)

'G' Grade (2)

and another about both leadership and management

'You have to be able to communicate incredibly well' and goes on to say that 'communication is very poor in management and is seen as very remote'

'G' Grade (3)

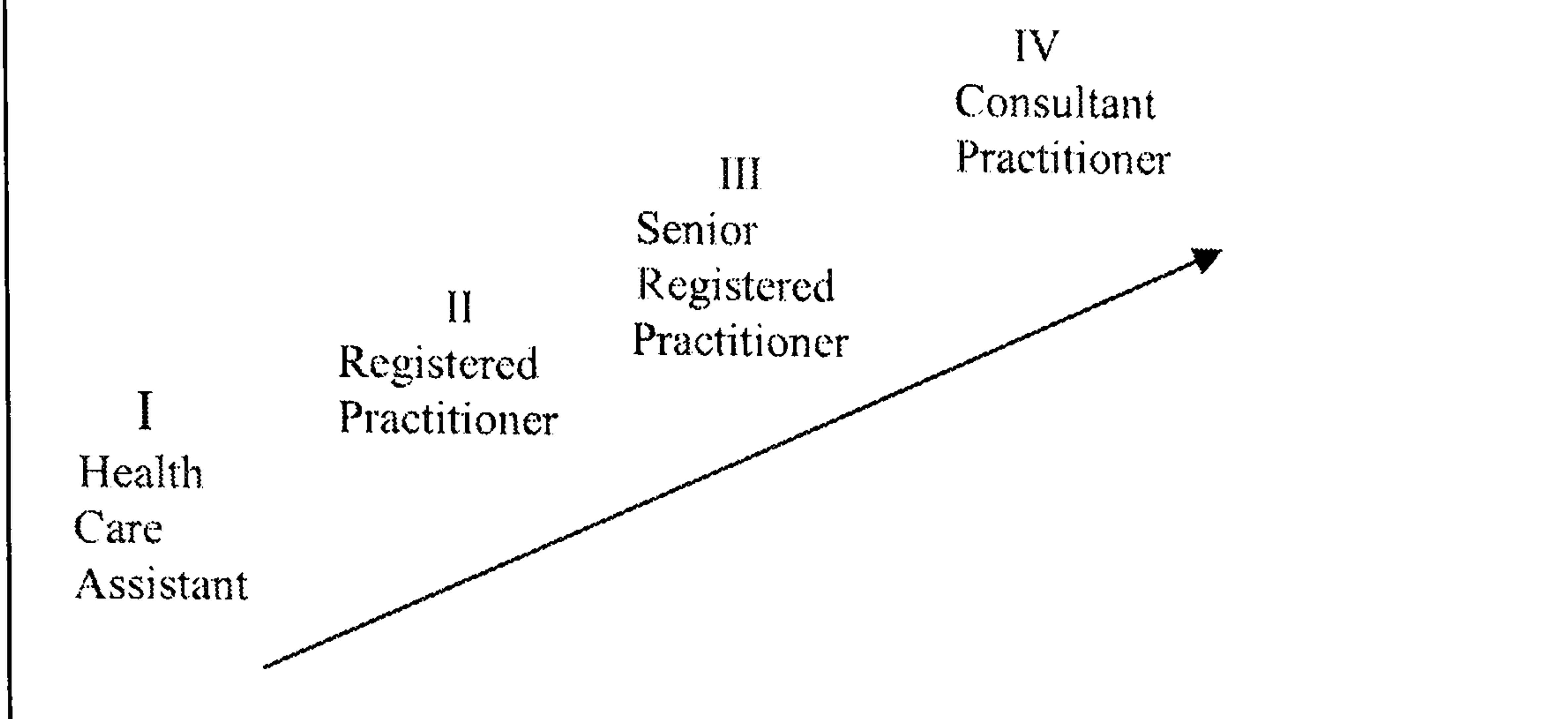
These findings accord well with Alimo-Metcalfe, (2001) and Alimo-Metcalfe and Alban-Metcalfe, (2001) research findings from their large studies.

Although only one other midwife informant mentioned poor communication, it is evident that communication per se is a real issue for midwives. Their experiences seem to point to very insular systems of communication within the individual NHS Trusts, almost a fortress mentality, whereby the masses (the staff) are kept in the dark about what is available for them either locally or in more formal CPD education. One can only hope that the managers do know what is available for staff and that although the midwives in this study only represent four NHS Trusts, other managers do communicate well and that the transparency exists in the publicity, selection and uptake of places on courses in other Trusts. Further research in this area is needed.

A final thought from the findings, points to the notion that the midwives can recognise leaders at different levels of their organisations. Even the 'E' Grade midwives talked about leaders emerging during the pre-registration basic training, although they were finding it more difficult to recognise those with leadership qualities in their current role. This perhaps is significant at the stage of development for them, during their preceptorship year. Finding one's place in a large organisation such as an NHS Trust when you are coming to terms with the role and responsibilities of being a qualified midwife means you are concentrating on getting the job right, rather than taking much notice of others aspiring to leadership in the future.

In *Making a Difference* DoH, (1999) the government explains its strategic intentions for nursing, midwifery and health visiting with a particular emphasis on strengthening nursing and midwifery leadership. They say they are committed to boost NHS leadership and management. The introduction of nurse, midwife and health visitor consultants and the new career framework they propose will support the development of professional expertise and leadership skills. Career moves between practice, education and research are encouraged in order to give potential leaders of the service a broader range of competencies. Clinical leadership at ward/department level will continue to rest with the Sister/Charge Nurse or 'G' Grades. These grades will also need to be developed further, as poor clinical leadership leads to poor Standards of Care (8.6). The report recommends that NHS Trusts should provide investment in clinical leadership programmes and professional development. Within the next few years, over 32,000 places are to be provided on the LEO programme, (DoH, 2000; NHSE, 2000b; Moiden, 2002). Trusts could utilise clinical supervision and statutory midwifery supervision processes to help identify support and develop staff already in leadership positions and for those who have potential. In addition, establish a process of effective succession planning to support those selected and coach those who aspire to leadership positions. Provide opportunities for formal and informal development, these include the Royal College of Nursing Leadership Course and the LEO programmes and generate activities such as secondments, job swaps, shadowing, 'acting-up' into roles and mentoring. A new career structure is proposed to replace the clinical grades. It is designed to provide better career progression and fairer rewards for team working, developing new skills and taking on extended roles (DoH, 2000). It also provides opportunities for professionals to combine or move laterally between jobs in practice, education and research.

Table 11 - Proposed Career Framework Career Trajectories:



Career Framework Source DOH 1999 (5.3) Making a Difference, London: DOH

The first wave of 200 consultant nurses and midwives have been appointed, the government plan is to create 1000 overall. These career posts have been constructed to improve quality and services as well as providing a new career opportunity to help retain experienced nurses and midwives and health visitors who might not otherwise remain in practice. Salaries will range from £30,000 to around £55,000 per annum. All consultant posts are structured to enable at least half the time available to be spent in clinical practice and in contact with patients and clients.

Midwifery Consultants have been appointed under a variety of job profiles and posts. Thirty four are in post in the United Kingdom, mainly in England, 1 in Scotland and 1 in Wales. Some of the appointments have been very successful with midwife consultants acting as excellent leadership role models. Joint appointments seem to be favoured, that is, appointments are constructed to operate with a proportion of the consultant's time in managing a caseload of clients and the remainder with the consultant linked or employed by another Trust or Trusts or university. Consultants are expected to lead on specific aspects of a service eg. Public Health, Teenage Pregnancies, Pregnant Drug Misuse or indeed, Normal Birth. The consultant posts are in addition to managerial posts with the majority being accountable and line managed by the HoM and also the HoM Education (HoM Ed) in the university. The future of these appointments and the extent to which they are judged as effective requires further research (Manley, 2000). They may be in the long term, if funding remains available, a

leadership role model but as there are currently so few, it is unlikely to make a great impact on the careers of midwives.

5.7 Summary

This chapter has discussed the main findings of the data generated from the three phases of the study. The interviews with the original three HoM's and two senior midwives with a national profile the seven core grades of midwives in the Service. This chapter has revealed a number of issues that need to be resolved within the profession.

The ageing profile of experienced HoM's is of concern as it is likely that within the next five years over a quarter of the current HoM's are likely to retire and with them, their experience is lost to the profession. From the informants interviewed, career planning and the long-term view is not foremost and certainly not planned for. Career aspirations and the generation of the career pathways is not a main feature in NHS Trusts. Identification of potential managers/leaders is not a co-ordinated process, although some of the respondents and informants expressed the fact that they could identify themselves or others as potential successors. Over half the HoM's and all the informants interviewed, mentioned that Trusts have mandatory training and most reported, the huge gap in finding out what courses are available to them outside of the Trusts and how to access places or funds in order to undertake CPD. Lower down in the organisation, less is available to them because of their lack of knowledge of what is available, Midwives reported 'queuing' and 'taking their turn'. Recognition of the qualities and skills needed in professional leadership were clearly articulated and it was apparent that, midwife informants could recognise leaders at different levels of their organisations.

Finally, with the consultant role developing and the DoH investment in clinical/leadership programmes, alongside the proposed changes in clinical grades to a career pathway from health care assistant to consultant practitioner, the service may see some investment and return in future years.

The next chapter sets out to explore in some detail the conclusions and developmental implications for the whole midwifery service.

CHAPTER 6

Conclusions and Recommendations for Development

6.1 Introduction

This chapter reports the main conclusions arising from the study. In the light of the research findings some recommendations for the future development of the maternity services are presented for consideration. The conclusions are reported for each of the research questions.

- a What are the perceptions of Maternity Service Managers, HoM's and Midwives of succession planning within the Maternity Services of the NHS in England?

The interview data, suggests that midwives perceive that succession planning within the service is currently haphazard, uncoordinated and that no one person has overall responsibility for the process. This gap is particularly noticeable at local NHS Trust level.

Of the three HoM's interviewed all three reported that they felt their previous post had prepared them for leadership responsibilities. They suggested that the support they had received from their HoM when they were in a more junior post had been the most influential element in their preparation. How they prepared or influenced Midwives was by personal support and giving feedback, by encouraging confidence in the person and in some cases encouraging attendance at relevant courses or meetings.

However, the ability of the HoM to identify a successor was less clear with only one informant confirming that an obvious successor could be identified. HoM's reported that they used personal observation, knowledge and contact with the potential successor to judge suitability and characteristics such as dedication (to the profession) good communication and management skills, as well as criteria such as being well qualified and knowledgeable. Therefore, we can conclude that some existing HoM's do have the ability to recognise potential leaders for the future, but others cannot or are

uncertain. This again is not wholly suggestive that the HoM's are not talent scouting but what is unclear from the evidence is the precise extent and the degree to which they are. There is not necessarily a direct correlation between those who are recognised and encouraged to aspire to leadership and the subsequent appointment or confirmation that they have done so. There may be several different inhibiting factors here. For example, constraints exist in Trusts whereby promotion to a higher position may involve the Trust identifying monies to support the increased salary from existing resources, this may not be possible. Therefore, some good candidates for promotion may look elsewhere for job opportunities and employment and are consequently lost to that Trust.

There appears to be a continuing and urgent need in the maternity services for midwives with leadership skills. The findings indicate the HoM's currently in post have an ageing profile with one quarter due to retire within the next 5-8 years (Tucker, 1999). If a leadership staffing crisis is to be avoided active steps must be taken to identify and train midwives who have the potential to take on leadership roles. This must not be confused with the existing or current style of succession planning: making sure that there is always someone to replace a person in a given post. What is needed is a comprehensive investment in developing the skills and talents of leadership, so that professionals including midwives can exercise those skills at whatever level they work within the service (DOH, 2001).

Leaders of the calibre needed by the NHS at all levels do not just emerge. The expectation that those who are skilled in one aspect of healthcare, or who have risen to a certain level of seniority in their profession, will by that fact alone automatically make good leaders is a myth. Leaders can be made, the skills of leadership can be taught, acquired and developed in most individuals. It will of course vary with individuals to what extent they will be able to utilise the skills.

Progress has been made since the data reported in this dissertation were collected. The NHS is currently funding leadership training by providing leadership programmes which include the NHS Leadership programme; the NHS Nurse Leadership programme and the Royal College of Nursing (RCN) Leadership programme. Furthermore, considerable money is being spent by the NHS on leadership programmes provided by

non-NHS bodies, such as the Kings Fund and various Universities and Business Schools. Possibly what is required is a proper assessment of the relative value of the many programmes offered, with a view to deciding which and what to support. Moreover, a greater emphasis on multi-professional programmes, which seek to integrate all aspects of patient or client care would seem to be more appropriate. Leadership programmes for nurses, midwives, doctors and for managers, learning together, to and from each other could only benefit the NHS (NHS Executive, 2001).

Trusts are now being encouraged to formalise appraisal or performance review systems. Ensuring that professionals have yearly reviews to help them review their role and develop a personal development plan (PDP's) should aid career planning and development. Professional development opportunities could include shadowing or acting-up opportunities; lateral moves within the organisation to learn new skills and continuing professional development education, perhaps to be sponsored for management and leadership training.

b What are the tasks/challenges of the leadership role within the Maternity Services?

Interview data, especially from the more senior members of the midwifery profession confirmed that they perceived the main challenge facing the service is that it should retain the ability to shape and influence its own future. The government since 1997 has embarked on ambitious programmes of policy reform associated with health care. This rapid change movement has significant implications for maternity care and midwives. The policy drivers shaping future development of midwifery care include: Primary Care-led NHS; Trust mergers, the public health agenda; clinical excellence; supporting families; devolution; cost effectiveness and the emergence of midwife-led units. These changes have the potential to give midwives a much broader role particularly in women's health and public health. Reform is under way with a greater emphasis on clinical excellence and enhanced pathways (DOH, 1999). However, if the reforms are to be successfully implemented, midwifery leadership will be crucial for professional development and high quality care. However, the development of flatter management structures has eroded midwifery leadership and career opportunities (RCM, 2000). With this erosion has come a loss of ability to influence within the NHS management

structures. Many HoM's are at significantly lower grades than their nurse colleagues and many have no voice at executive level in the Trust. If these losses are to be reversed action is necessary to promote leadership across the clinical, managerial and educational spheres.

Career development opportunities which promote and encourage midwives to embrace, innovate and sustain new ways of working should improve recruitment and retention issues. HoM's should be encouraged to try out different ways of staffing the maternity services such as caseload practice/midwifery group practices; local midwife-managed services; team midwifery or an autonomous contractual model or one-to-one care (DOH, 1993). Some of these models offer for midwives exciting opportunities for a more creative, locally accountable midwifery service. They also pose threats such as inequalities in provision, higher costs and to some extent fragmentation of the current UK-wide bodies, policies and pay systems (RCM, 2000). However, it is important to stress that midwives must take control over these changes themselves, otherwise government will impose structures which may perpetuate problems as in the 1990s (Ham, 1982; Dixon et al, 2000).

A further development has been that the Department of Health (DOH, 1999) has proposed new career structures which incorporate consultant posts to replace the existing clinical grades for nurses, midwives and health visitors. These posts are designed to extend the career ladder of some practitioners, who might have otherwise moved to education or management, to remain in clinical practice whilst improving their status and pay. These consultant posts are specifically established to help improve the quality of the service and provide a new career opportunity for experienced expert practitioners and provide a leadership focus within NHS Trusts. Currently, midwifery has 32 Consultant posts in England, and the second wave of posts is already being considered. However, a total of 2000 is the final number planned, from the total workforce of nurses, midwives and health visitors. Therefore the number of posts in midwifery is not likely to be more than 100, which is not one consultant midwife per average sized maternity unit.

- c How well do E F and G grade midwives feel prepared for the role of leadership?

In the interviews with midwives it was clear they all had some vision of their own future. The 'E' grade midwives interviewed were less clear of their career progression, preferring as they said to spend the initial years of their practice, 'consolidating their experience'. More worrying were the responses from the 'F' grade midwives who expressed some frustration at being trapped or left out of career opportunities. One 'G' grade midwife did aspire to the new consultant midwife post and another one referred to having someone who she relied upon to act as a mentor to her, but the others were less clear about who or where they would go to seek career advice. There is much scope for development in this area and further research needed if midwives are indeed going to challenge the status quo, create new roles to improve job satisfaction, accept the leadership mantle and forge a quality service for their clients.

The evidence from the interviews which was supported by the data, indicate the perceived significance of midwives continuing the learning process either through different experiences or formal study. The results did not suggest that any activity was regarded as more significant than another. What was important was the fact that those who were in significant positions or those who aspired to such positions who had had the opportunity of different experiences or going on courses felt they had benefited from such experience. The most popular courses seemed to be Trust based short programmes such as: Rainbow, Springboard and other similar programmes with a National Vocational Qualification (NVQ) attached. Opportunities to enrol on non-NHS programmes and those run by Universities or Business Schools were less frequently reported by the informants.

Midwives are encouraged throughout their basic registration educational programme to learn the skills of lifelong learning. Systems need to be in place throughout a qualified practitioner's professional life to ensure professional competence. These systems include not just reaching educational standards during training, but also continuing professional development (CPD). Thus the employer should have in place systems and resources to enable and support professionals to maintain and develop competence as well as systems to identify and act on failing or poor performance as early as possible. The arrangements to ensure that professionals maintain and develop their competence are currently fragmentary and although in some circumstances prescribed, for example

CPD is a requirement of continued practice (UKCC, 1997). CPD is part of a process of lifelong learning. Its purpose is two-fold, firstly it is associated with maintaining and developing competence in order to care for patients. Secondly, it is to help professionals to be fulfilled in their work.

Although not all CPD activity is necessarily strictly aligned to the professional's job, employers should realise that CPD is not just attending courses or conferences, other strategies which would enhance professional development within the workplace might involve job-swaps, career breaks, sabbatical opportunities, secondments, mentorship or coaching etc. Since April 2000 all NHS Trusts have been required to have in place a training and development plan. Such plans seek to ensure that the resources devoted to continuing professional development meet the needs of the client group and the aspirations of individual professions. Providing incentives for professionals thereby helps to attract and retain highly motivated professional individuals.

The Making a Difference (DOH, 1999) report made reference to capitalising on CPD activity and lifelong learning with the aim of strengthening nursing and midwifery to develop a modern career framework linked to professional development and periodic re-registration. This significant mandate is designed to prepare nurses and midwives to meet the challenge for change.

d What are the implications for future leaders of midwifery?

The evidence from the interview data indicated that midwives wanted from their leaders a repertoire of skills and attributes that encompass the description of strong, professional and visionary. Other attributes that midwives felt were important in a leader were understanding, ability to communicate and being flexible. These are useful skills to acquire or develop when in a leadership role. Authors such as Adams, (1986); Cross, (1996); Bass, (1990) agree especially when organisations are undergoing rapid change and development. Another finding in this research was the significance of having or being a role model. The majority of midwife respondents felt it was very important to have positive role models in the profession. Role models provide an observable image for imitation, someone who demonstrates skills and qualities for followers to emulate (Morton-Cooper and Palmer, 1993). Role models work to

develop relationships in organisational structures and they can provide several levels of support to another professional. Support systems have always existed in the maternity services either informally or formally, perhaps seen more as the lubrication that helps teams to work together harmoniously. Maternity care is becoming increasingly more complex, the demands of new technology, the changing nature of the organisation, increasing burdens being placed on midwives such as client expectations, increased litigation and midwives being carried along on an unstoppable tide of change and confusion. During these times it is important to develop supportive frameworks which encourage individual growth, enhance motivation and nurture leadership qualities. These support mechanisms can involve mentoring, coaching and teaching as well as role modelling. In Rawlins' (1983) words, role modelling involves the process of identification, observation, initiation and comparison to 'visible experts'. Adoption of a supportive framework including role modelling would seem a sensible option in the development of leadership qualities in potential leaders of midwifery.

The message that senior midwives should be strong, professional and visionary has been heard for at least two decades in important reports setting out the manifesto for the future development of midwifery care (RCM, 1987; WHO, 1985; DOH, 1993). It was argued that the key task of the maternity services was to embrace diversity, tackle inequalities (Acheson, 1998) and develop stronger partnerships with the communities which they served. A stronger more autonomous role for the midwife which could provide seamless individualised care across community and hospital settings was advocated (RCM, 2000). Midwives were to work as the lead professional for the majority of maternity clients, the previous model of medical care was to be replaced once and for all by a health model of care based on the premise that pregnancy and child birth are normal. Finally, within this fast moving reform of the NHS, with the introduction of new policies and new structures such as primary care groups and Trusts which will have a significant impact on the purchasing of maternity services (DOH, 1997; DOH, 1998; DOH, 1999), the maternity services will move away from the dominance of the obstetrician towards a model of normality and women-centredness (DOH, 1993). Midwifery leadership is vital for professional development and the provision of high quality care. Some would argue that with the introduction of the consultant midwife the profession had succeeded in its mission to lead itself. However,

leadership needs to be exercised at different levels in the maternity services, and invested in many midwives, so that succession planning is assured.

A further implication for future midwifery leaders highlighted by the research is the need to manage stress. The research findings confirmed that a high proportion of the midwife respondents' perceived their role as stressful, demanding or highly pressured. Their coping mechanisms seemed to be organised around having supportive staff and colleagues, a supportive home life, undertaking leisure activities (eg. hobbies, exercise, gardening) and leaving work at work. Those leaders who seemed to cope reported that they aimed to stay focused and calm and to delegate to and develop others in the team to ensure that the maternity services did not suffer from the leaders taking on additional projects. The need to balance their work and home lives within the leadership role was also commented on by the informants. Using other professionals, senior professionals to share problems and networking within Trusts seems to be popular, some respondents commenting on the value of having senior colleagues who can advise, mentor or counsel them. The message for leaders would seem to be to devise a survival kit for themselves that includes setting up networks, managing time, saying no, learning to delegate tasks efficiently and effectively and not taking too much work home at nights and weekends. Several respondents in this study referred to working longer hours or taking work home in order to stay ahead of the job. Without adequate rest and sleep plus other leisure stimuli, the individual will eventually succumb to minor illnesses or start exhibiting the symptoms and signs of stress related illnesses (Carlisle et al, 1994; Sandall, 1997; Jenkins and Roger, 1997). Stress has been researched in health professionals and midwives specifically in particularly aspects of their role (Sacker,1990) Special Care Baby Units (Stewart,1990), the role of technology in care (Santangeli,1998) and changes to the delivery of the maternity services (Prout and Pearson, 1989). All these studies along with more recent work of Carlisle et al, (1994) and Wheeler and Riding, (1994) can be summarised as the following: workload, organisational issues, interpersonal relationships and poor working conditions, are the main sources of stress. Generalisation of these research findings to the whole population of midwives is not possible, as the studies were small and concentrated on clinical midwives and not manager/leader grades. But nevertheless the findings do indicate that midwives work within very stress-making environments.

From the organisation's perspective, stress has a real financial cost in terms of decreased work rate, increased sickness/absenteeism, inability to accept change, accidents and errors. The responsibility for dealing with stress in the UK has been regarded as lying with the individual rather than the organisation. However, managers are recognising the importance of not just monitoring the levels of stress but in working positively to create less stressful environments for their staff (CBI, 1997). Commitment to managing stress is now recognised as essential to all organisations, including the NHS. Senior managers are charged with the responsibility of overseeing all workbased activities, monitoring sickness and absenteeism rates and working proactively to reduce stresses. Particularly at times of change by communicating and conducting damage limitation techniques, ensure that staff have health checks, ensure staff take their annual leave and discourage the 'long hours' culture which seemed to be present in the research evidence.

Caring for the carers has been a campaign within the NHS to improve the working conditions of all health care professionals (Caldwell et al, 1995). Midwives have always expressed the term 'carer' through service and sacrifice (Kirkham, 2000). Midwives are professional carers who discounted their own need for personal and professional support (Kirkham, 2000). Midwives can no longer ignore the fact that they too need support to undertake the role of a midwife. Mothers expect to be empowered to make their own decisions. Midwives cannot empower mothers, if they themselves are not empowered or not acting as if they are. Midwives need to appreciate they too require a caring, supportive, empowering environment to work within. Some NHS organisations have instigated caring for the carers programmes which include counselling services for staff. Regular training occurs whereby courses on counselling are held for staff who have to provide counselling input in their daily work e.g. bereavement, antenatal screening tests. Other activities include self-awareness, relaxation tapes and massage sessions. Some employed a psychotherapist to work with staff on a regular basis to improve communication, general coping skills and teambuilding. One such scheme in Exeter, (1996), was set up by a midwife leader for midwives in the Trust. The take-up of the scheme has been good and continues to be successful, with sickness levels reported as low at four per cent per annum (Caldwell et al, 1995). Unfortunately, not all Trusts are as visionary as Exeter.

Therefore a lot of NHS staff are still working in difficult and unsupported environments (Unison, 2004).

6.2 Limitations of the Study

This dissertation has been researched and written over a number of years, which brings about its own limitations as well as strengths. The consequences of part-time study and of engaging and re-engaging with the study over a number of years, means that some elements of the study have been superceded. For instance, this current government has repeatedly examined the NHS and found it wanting as far as leadership and succession planning are concerned. So much so that improvement in this area has become a major target for NHS Trusts to achieve. Exactly how Trusts are to affect this process is less clear. In Regional Health Authorities leadership champions have been appointed and the LEO programme is being rolled-out throughout England. This however may not be enough. It could be a further example of what Adams (1995) describes as the usual NHS 'sticking plaster' approach to government initiatives, without a meaningful evaluation of the mechanism needed to firstly identify the next generation of leaders and then ensure they are given the opportunity to demonstrate their abilities, with effective mentorship and appropriate training for the long term. Once again a short-term 'quick fix' approach may have been used rather than a longer-term solution.

The study is restricted to HoM's in England currently in post at the time, 1998/9, prior to any major government initiatives. The NHS is a United Kingdom institution however, since devolution of Scotland and the construction of the Welsh Assembly, some of the findings in this study may not be transferable to similar organisations in Scotland, Wales or Northern Ireland.

6.3 Strengths of the Study

This is the first study in the UK conducted on this cohort of subjects, Heads of Midwifery (HoM's). It has proved to be very illuminating from an organisational perspective. Considerable pressure is exerted on HoM's from the organisation (NHS) to operationalise DoH strategies, to work collaboratively within the multiprofessional team and to work within finite and in some cases diminishing financial and general

resources, eg. workforce capacity, capability, recruitment and retention crisis. These major managerial issues are being handled within the massive arena of NHS organisational change.

The qualitative methodological approach to the study was considered to be appropriate. Where there are no theories or information available, then a qualitative study informed by elements of grounded theory creates a new theory or substantive finding illuminates the subject area, perhaps creates more questions than answers but at least starts the process of investigation.

CHAPTER 7

7.1 Suggestions for Future Research

- Research is needed into human resource issues, service delivery and organisation for the NHS, very particularly for the Maternity Services. So far, evaluation of new innovations as part of the NHS modernisation programmes has, like so many other changes that the staff have experienced, been unreported and unevaluated. It would seem advantageous for the NHS to link the leadership centres and the programmes they provide into evaluative research, with academic underpinning from Higher Education including eventually the NHS University (NHSU).
- Investigate the impact of Consultant Nurses and Midwives on the NHS Trusts. Will they make a difference to the quality of care experienced by the patient/client?
- Investigate informal leadership networks and continuity and change.
- In the light of the findings in this study to investigate HOMs using a case study approach, in different regions in England.

7.2 Recommendations for the development of the midwifery service

National level:

- There should be a champion for leadership in every NHS trust, not just at Regional Health Authority level. The role of such a person would be to co-ordinate all the activities needed to identify and train future leaders.
- Leadership programmes should be centrally co-ordinated by Government under the umbrella of an NHS Leadership Centre, which would be funded and sustained in a way which is consistent with the recommendations in the Government report (DOH, 2001)
- NHS organisations and the maternity services should investigate good practice on stress relieving activities for all staff and implement a strategy for stress management.

NHS Trust:

- Annual appraisal or performance review should become the norm in the organisation and professional development plans should be introduced for all professional staff at every level in the Trust.
- Resources should be channelled into developing leadership programmes for all aspiring midwives irrespective of grade. These programmes should be multi-professional in nature thereby giving midwives and other health professionals the opportunity for collaborative learning. The LEO programme and other similar WDC support programmes should be included in this provision.
- Specific attention should be given to mapping career progress from the newly qualified midwife or midwife returning to practice up to and including those retiring from service. This needs to be undertaken to ensure potential talent is not lost to the organisation.
- Secondment opportunities could be offered within NHS Trusts or across Trusts and also with Universities to broaden and enhance the midwife's experience eg. Lecturer/Practitioner posts. Collaboration between education and the NHS service providers in providing leadership training should be increased.
- The systems for the provision of CPD in NHS Trusts should be made more transparent. Resources available to support professional development activities should provide funds to cover study time and replacement costs.
- Leadership development programmes should include stress and time management and assertiveness skills as well as the usual topics of managing resources, people and change.

Midwifery Services:

- HoM's should be responsible for identifying potential leaders from their staff.
- Statutory midwifery supervision should be used to identify and develop clinical leadership skills amongst midwives.
- HoM's should be responsible for developing the potential of their staff, through helping them draw up personal development plans, arising from appraisal and statutory supervision annual interviews.

- CPD for midwives throughout their professional working lives should be linked to appraisal and personal development plans.
- Career planning should involve the midwife and their manager looking at different ways of creating job opportunities such as shadowing managers or midwife consultants or midwives in key positions, e.g. practice development, central delivery suite manager. Acting-up activities and project work should be rotated through staff with potential.
- Role modelling should be encouraged in the maternity services
- Supportive systems should be in place in all maternity services. These systems should include networking and mentoring for all midwives.
- Midwifery leaders should be encouraged to balance their work activities with home life and leisure pursuits (eg. networking).
- Midwifery leaders should ensure that they encourage their staff and themselves to take their annual leave entitlement and monitor that they do.
- Midwifery leaders should discourage the culture of working of 'long hours'.

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Example of the Open Codes & Main Themes from Interviews with the three Heads of Midwifery

| Open Codes | Main Theme |
|---|---|
| <ul style="list-style-type: none">• Career story so far?• Years in post?• Opportunistic promotions.• Lateral moves• Age profiles• Gender.• It's for you! 'Right Place, Right Time' | <ul style="list-style-type: none">• Current Post, Career Biography |
| <ul style="list-style-type: none">• Previous posts.• Preparation for post.• 'Acting up'• Planned to promotion.• Encouraged by significant person.• More from small unit to bigger.• 'Stretching themselves' | <ul style="list-style-type: none">• Career Aspirations |
| <ul style="list-style-type: none">• Ethic of service.• Culture of midwifery.• Difficulties in accessing courses.• Queuing.• In-service activities have priority.• Compulsory training e.g. BLS. | <ul style="list-style-type: none">• Local Availability of Resources |

Example of the Open Codes and Main Themes from Interviews with the three Heads of Midwifery (cont'd)

| Open Codes | Main Theme |
|--|--|
| <ul style="list-style-type: none">• Difficult to access.• Who do you ask?• What's available?• Funding issues/replacement or back fill issues.• 'G' grades have priority. | <ul style="list-style-type: none">• Formal CPD Opportunities |
| <ul style="list-style-type: none">• Personal traits important.• Positive description.• Supervision of midwives – annual review.• Not the same.• Stressful.• Management styles.• Proteges.• Role Models. | <ul style="list-style-type: none">• Professional Leadership and Management |

Section of transcribed interview data from one of the Senior Midwives with a National profile

| | |
|----|---|
| 1 | In the better units they have a definite strategy, they |
| 2 | are supported and nurtured, the relationship |
| 3 | between the Trust nurse and Head of Midwifery is |
| 4 | important. Unfortunately if the HoM is |
| 5 | perceived as able she can be plucked out/singled |
| 6 | out for a different role, such as project officer |
| 7 | or professional development role. These managers |
| 8 | are seen by the executive of the Trust as |
| 9 | valuable and successful in these roles. I have |
| 10 | seen several move away from Midwifery |
| 11 | some units that they visit have the most senior |
| 12 | midwife at only 'H' grade, which is too |
| 13 | low, these managers are often too busy and |
| 14 | challenged, with no role models and are |
| 15 | counted as 'hands on' staff. Or in some |
| 16 | cases (she) knows of some leaders who are |
| 17 | there (in post) and cannot move on, the |
| 18 | service 'ticks over' and (she) believes client |
| 19 | needs are not being met |

Strauss and Corbin (1998) recommend that initially at least, the interview material should be analysed line by line. This is open coding. The potential codes that are generated by this process should reflect the main concepts. Looking over the first 19 lines there are a number of codes that can be applied to the text. After reading the extract several times it becomes clear that role modelling is an important concept of key issue (amongst several). I then asked questions such as what factors are at play here, and do other informants hold similar views?

Consequently, role modelling is likely to become a category/theme as opposed to a single code. It is important that each new code is defined clearly. It's the questioning of the data that leads to new concepts developing. The process is characteristic of constant comparative method (Strauss and Corbin, 1998).

From this single extract several codes emerged.

| | |
|------------|--------------------------------------|
| Line 1-2 | Better units, supported and nurtured |
| Line 2-4 | Relationships |
| Line 5-9 | Recognition |
| Line 10 | Move away |
| Line 11-14 | Low grade, no role models |
| Line 15-16 | ‘Hands-on’ |
| Line 17-19 | Service ‘ticks over’, needs not met |

Open Codes and Themes arising from the transcripts of the interviews with E F & G grade midwives:-

Theme 1: Career Autobiography

Planned/unplanned
Encouraged by someone
Enthusiastic
Goals
Pride
Ambitions
Achievement
Confidence
Consolidated training
Pleased with progress to date
Range of years 5-7yrs exclude 'E'
Transferable skills past career
Maximise opportunities
'Pushy'
'Seek it'

Theme 2: Career Aspirations in Management

See a future
Viewed positively
Not all in management/ed
'E' short term vision
Organisational issues
HRM strategy or lack of it
Culture of midwifery – queuing, not my turn
Role model - Poor
Preceptorship/Buddying

Theme 3: The Qualities of a Professional Leader

Flexible for both (inc management)
Well educated - emerge at different levels
Stand their ground
Role models
Innovate
Assertiveness
Change agent
Craft the profession

Theme 4: Formal CPD

Links with HEI some EPC for some CPD (bid)
Midwives not always in the know
Information 'patchy'. What's on!
How to apply?
Funding?
Who to ask for help?
Study leave issues
Use negotiation/skills/bargaining
No real encouragement or planning
Supervisory interview (yearly)
Appraisal

Theme 5: Local availability of Opportunities/Resources

Culture of midwifery
Part-time staff
Queuing
Waiting lists
Turnover of staff
Difference between comm/acute
Link with EPC for some courses
Organisation in Trusts haphazard
Seek it/find it yourself
Information not readily available
You have to push, be proactive
Managers not proactive
Career advice lacking from within the service
Individuals may have someone, coach/mentor
When you're a 'G' grade they may develop,
below 'G', no.
Other developments, swaps, secondments, shadowing,
projects are limited

Theme 6: Qualities of a Manager

Business skills
Scheduling
Strategic planning
Knowledge of the service
Flexible

Meyerson and Martin Culture Scheme (1987)

| Scheme or Views | Meaning | Effect on Cultural Change |
|-------------------|---|---|
| 1 Integration | The social or normative glue that holds together a potentially diverse group of members. ‘An integrating force’. | An organisational wide shift in attitudes or beliefs is needed, usually manipulated by senior managers. |
| 2 Differentiation | That the culture is composed of collections of values and beliefs, not necessarily held by all members. There are/may be disparate identifiable sub-cultures. ‘Contradictions’. | Usually a localised and incremental change that will be influenced by many and varied factors both in and out of the organisation. |
| 3 Ambiguity | Suggests that the culture has several manifestations characterised by differences of values and meanings, consensus, variance and confusion co-exist. ‘Complexity’. | Culture is continually changing based on the interpretations and patterns of connections between individuals forming and reforming. |

Appendix 5

Proforma for Interviews with the Three Heads of Midwifery

- | | |
|------------|--|
| Question 1 | How long have you been in this current post? |
| Question 2 | Can you tell me how you got into this post? Give me a short history of your career so far. |
| Question 3 | Can you tell me something of the size and type of service you manage? |
| Question 4 | Can you tell me how the job previous to this one prepared you for your current job? |
| Question 5 | How have you adjusted to your new role? |
| Question 6 | How would you describe your coping mechanisms? |
| Question 7 | Can you see an obvious successor for your role in the Trust? |
| Question 8 | How do you prepare your 'G' grade midwives for leadership and management roles? |
| Question 9 | What is available in the Trust to develop potential leaders or managers for the future? |

Proforma for Interviews with Two Key Midwives in the Profession

- | | |
|------------|---|
| Question 1 | Does your organisation have a strategy on succession planning to help midwives from 'G' grade and above into management and leadership positions? |
| Question 2 | What is the role of your organisation in taking the lead if an initiative is needed and who will take this forward? |
| Question 3 | What are your views of succession planning in the Maternity Services? |
| Question 4 | Midwifery services and education is approaching a crisis in succession planning where do you see the next generation of leaders and managers coming from? |

Proforma for Interviews with ‘E’, ‘F’ and ‘G’ grade Midwives

Themes

| | | |
|-----------|------------|---|
| Personal | Question 1 | How do you see your career progressing? |
| Local | Question 2 | What is available in this Trust for you to achieve your goals? |
| CPD | Question 3 | What learning opportunities have been available to progress your career? What type of courses? |
| Personal | Question 4 | Have you ever considered applying for a managerial post in a Trust? |
| Qualities | Question 5 | What skills are needed to manage the Service today? |
| Personal | Question 6 | Would you consider leaving your current post and applying for a manager’s post elsewhere, if the opportunity arose? |
| Manage | Question 7 | Is there a difference between professional leadership and management? What terms would you use for them? |

